



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
Mississippi**

**Application for 2015  
Annual Report for 2013**



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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section. IA - Letter of Transmittal***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **C. Assurances and Certifications**

The MSDH has a copy of the Assurances and Certifications on file. If you wish to review this file, please contact John Justice, MCH Block Grant Coordinator, by email at [john.justice@msdh.state.ms.us](mailto:john.justice@msdh.state.ms.us) or phone at (601) 576-7688.

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

### **E. Public Input**

The Mississippi State Department of Health (MSDH) solicits public input from the agency's MCH Block Grant webpage to maximize the opportunity for residents and community leaders to make comments and discuss their concerns. Copies of the MCH Block Grant are made available to community health centers and each of the nine MSDH public health district offices to allow residents the opportunity to visit and view these documents at their convenience.

As a part of the 2011 Application/2009 Annual Report, MSDH conducted and completed its five year needs assessment. Public input was solicited in the form of online consumer surveys and needs assessment conferences and/or meetings with professionals and consumers alike. For a more detailed narrative description of the needs assessment process, please view the attached needs assessment document.

Input is also solicited during the normal course of business from agency partners at meetings held across the state throughout the year. For example, offices within the MSDH Office of Health Services met with, among others, the Mississippi Primary Health Care Association (representative group of the state's community health centers), the Delta Health Alliance (a partnership that coordinates and provides oversight for community-based programs that address critical healthcare and wellness gaps in the Delta), the University of Mississippi Medical Center, and the Pregnancy Risk Assessment and Monitoring System (PRAMS) Advisory Board and sought their input on the state's needs assessment and the MCH Block Grant.

Public input also continues to be solicited through key parent and family support groups who are affiliated with programs funded by the grant.

/2013/ Beginning in the fall of 2012, the MSDH Title V MCH Block Grant website will be enhanced to facilitate public input in the form of ideas, comments and/or concerns about needs or programs. The Title V MCH Block Grant Coordinator will work with MSDH Communications website specialists to achieve these enhancements with the purpose of increasing public input into the Title V application and needs assessment process.

/2014/ "Suggestion Boxes" were added to the Title V MCH Block Grant and other maternal and child health webpages requesting public input in the form of ideas, comments, or concerns about maternal and child health needs and programs in Mississippi with the goal to enhance Mississippi's Title V application. //2014//

***/2015/ Suggestion Box feedback is and will be used to inform Mississippi's ongoing needs assessment and the 2015 Needs Assessment due July 2015. Feedback is also used to inform current program policy and objectives as needed. //2015//***

Current copies of the Title V MCH Block Grant narrative and data forms are posted on the MSDH website throughout the year. The website has links to the federal HRSA website where a snapshot of MCH in Mississippi can be found as well as the ability to perform detailed Title V MCH Block Grant narrative and data searches using the federal Title V Information Service. A link to the Association of Maternal and Child Health Programs (AMCHP) website that has detailed information on MCH in Mississippi will be added this fall.

/2014/ A link to the AMCHP State Snapshot of Mississippi webpage was added to the Title V MCH Block Grant webpage. //2014//

***/2015/ The MSDH Title V website is updated at least annually to include current copies of the Title V MCH Block Grant narrative and data forms and links to the federal HRSA website containing a snapshot of MCH in Mississippi and the ability to perform detailed Title V MCH Block Grant narrative and data searches using the federal Title V Information Service. //2015//***

The MSDH also maintains accounts with both Facebook and Twitter. Links to both accounts are found on the MSDH website at [http://msdh.ms.gov/msdhsite/\\_static/23,0,327.html](http://msdh.ms.gov/msdhsite/_static/23,0,327.html). Maternal and child health inquiries regarding the block grant received through Facebook and/or Twitter are forwarded to MSDH Health Services where appropriate staff respond and provide requested information. //2013//

## II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

### C. Needs Assessment Summary

#### Needs Assessment Summary

MSDH finds itself in the same situation as with most public health providers. Dwindling funding sources and government cutbacks have resulted in some reduced systems capacity. MSDH recognizes the value of ongoing needs assessment activities, but has been unable to focus on significant activities beyond monitoring and surveillance efforts to support the current state indicators and priorities.

The MSDH Title V program is in a state of transition after the previous long-serving Title V Director retired at the end of May 2012, and the new Title V Director began June 2012. As the transition in leadership evolves, some priorities and program foci may evolve as well. At the current time, reporting of any significant changes in population strengths/needs or operational activities would be preliminary and may be inconsistent with variations that occur in the near future while the leadership transition is ongoing.

//2014/ Due to dwindling resources (both financial and human), MSDH efforts towards ongoing needs assessment tasks have been dependent upon free or low cost opportunities. MSDH applied and was chosen to be a host site for an MCHB Graduate Student Epidemiology Program (GSEP) student for the summer of CY 2013. The student will complete a 12-week onsite assignment during May to August. The assignment project is to complete an evaluation of at least two MCH programs implemented during the current 5-year cycle. The findings are to be incorporated into the 5-year needs assessment. Also, Dr. Juanita Graham, RN, the public health nurse that coordinates the MCH needs assessment, has received a scholarship to attend MCHB epidemiology intermediate course training. The training will occur during late spring/early summer 2013 and includes planning, implementation, and analysis strategies for the Title V needs assessment. //2014//

***//2015// The MSDH is currently implementing the foundational activities required to attain public health accreditation through the Public Health Accreditation Board (PHAB). Part of the PHAB mandates include a comprehensive, statewide needs assessment. The MCH program at MSDH views this as an opportunity to collaborate and minimize duplication of efforts. The Title V Needs Assessment Coordinator is working with the team conducting the statewide needs assessment for accreditation to assure that the process incorporates the required components, including engaging the necessary stakeholders, to utilize accreditation needs assessment process for the Title V needs assessment purposes.***

***The accreditation needs assessment will be completed in late summer to early fall 2014, just in time to begin final efforts for identifying the Title V state priorities for the next 5-year cycle. The accreditation needs assessment will culminate in a list of health priorities for the entire state public health agency. We will utilize the data collected to define the state MCH priorities for the next 5-year cycle. That process will include engaging MCH-specific stakeholders to review the data and available report to assist in prioritizing the MCH component of the full needs assessment findings.***

***However, a concern for MCH program staff is the lack of information available regarding the Title V 3.0 transformation. Limited information was available in late January via the virtual Town Hall session offered by Dr. Michael Lu, and also across many sessions during***

***the annual conference of the Association of Maternal and child Health Providers (AMCHP).***

***As indicated in those venues, the transformation will greatly impact the design and deliverables for the next 5-year needs assessment cycle. Key MCH staff within Health Services have begun attending the virtual trainings offered by the MCHB and eagerly await additional information and detailed expectations for the "Needs Assessment 3.0" transformation. //2015//***

#### Pregnancy-Associated Mortality Review (PAMR)

/2014/ From 2010 to 2011, the number of pregnancy-associated maternal deaths in Mississippi rose by 58% and the rate of death due to pregnancy complications rose by 50%. Three year rolling averages for the past 30 years suggest that deaths due to pregnancy associated causes have been steadily rising among Mississippi mothers. Although relatively small, the numbers must be investigated to determine if: (1) Changes in coding of pregnancy-associated deaths have occurred, (2) Appropriate inclusion/exclusion criteria were utilized to calculate the numbers/rates, (3) Causal data on the death certificates were accurate, and (4) Verified data reveal opportunities to prevent recurrence of pregnancy-associated mortality among Mississippi women.

The Office of Women's Health initiated a special project to investigate the items listed above. Health record sources were visited and data essential to the record verification and maternal death review process were abstracted. No memoranda of understanding for the purposes of abstracting records from neighboring states existed. Thus, those data were unavailable. However, efforts have been initiated to establish a memorandum of understanding with a large provider in Mobile, AL. A meeting is scheduled for mid-June, 2013. Records were collected for the remaining 17 cases and those de-identified cases will be discussed during a case review team meeting to be held prior to the end of the FY 2013. A preliminary report of general descriptive data was submitted to the State Health Officer in early January 2013.

The CDC-Assignee/State MCH Epidemiologist, Dr. Connie Bish, who recently left MSDH, provided technical assistance to the planning process for this investigation. Dr. Mary Currier, the Mississippi State Health Officer, will contact the CDC for technical assistance specific to maternal mortality review. The team will seek technical advice towards understanding the data, accessing available data collection/management tools, and gaining support for formal implementation of a Pregnancy-Associated Mortality Review (PAMR) within the MSDH.

The preliminary and final reports for this activity will also inform the ongoing Title V Block Grant Needs Assessment efforts. The reports will answer two Needs Assessment questions: (1) If data issues resulted in the increasing numbers/rates, what educational or administrative actions, if any, are needed to correct the problem, and (2) If health or socioeconomic issues resulted in the increasing numbers/rates, what population-based interventions are needed to reduce the numbers/rates? //2014//

***//2015// During late 2012, the Agency conducted record abstractions for pregnancy-associated maternal deaths that occurred in Mississippi during calendar years 2011-2012. The record abstractions were conducted by an RN nurse who has experience and training in forensic nursing and mortality surveillance. Travel support was derived from the State Systems Development Initiative (SSDI) funding. Descriptive reports were generated from de-identified case data. The total 3-year (2010-2012) average PRMR (pregnancy related mortality rate) for MS was 39.7 deaths per 100,000 live births. The white PRMR was 29.3 and the black PRMR was 54.7. The most recent U.S. PRMR was 17.8 (2009) and the Healthy People 2020 PRMR goal is 11.4 indicating a more than 70% reduction in Mississippi's PRMR is warranted. Among Mississippi women who died during or within one year of pregnancy between January 1, 2011, and December 31, 2012, the most common demographic was a nonwhite female between 20 and 29 years of age who held a high school diploma or equivalent, and was actively employed. //2015//***

## Prioritization of Needs

//2014/ After much deliberation by the Mississippi Title V MCH Block Grant Work Group, a group comprised of maternal and child health stakeholders, who guide the Title V application process, made a unanimous decision to delete bullying as a listed priority and add preconception and interconception care as standalone priorities. Bullying will continue to be addressed by MSDH programs and their partners and is viewed as an important issue with far reaching consequences but there were too few data to substantiate a program or indicator and to inform progress toward stated goals.

Preconception care was previously listed with low birthweight and preterm birth but has now been separated out and combined with interconception care. Maternal health before, during and after pregnancy is a significant contributor to both maternal and infant morbidity and mortality. Adequate birth spacing allows for women to improve health and social risk factors and improves outcomes in pregnancy and for developing children. State Performance Measure 11 was adopted to capture data around pregnancy spacing and describe programmatic activities that encourage healthy family planning practices. //2014//



### III. State Overview

#### A. Overview

##### Geography

Mississippi is a heavily forested and largely rural state located in the Deep South and bordered on the north by Tennessee, Alabama to the east, Arkansas and Louisiana to the west, and Louisiana and the Gulf of Mexico to the south. Named for the river that flows along its western border, whose name comes from the Ojibwe word for "Great River," Mississippi leads the nation in catfish production and is the birthplace of the iconic American musical genre known as the "blues." The name "blues" hints at our sad history with its links to slavery and the unequal apportionment of fundamental rights that many take for granted today. This unequalness is evidenced by significant disparities that continue to exist throughout the state in economics, education, and health.

The state population was 2,938,618 in 2008, up 3.3 percent from the year 2000, and is divided into 82 counties with a total land area of approximately 47,000 square miles. Only three cities in Mississippi had populations that exceeded 50,000 in 2008: Jackson, the capitol, located in the west central part of the state (173,861); Gulfport on the coast (70,055); and Hattiesburg in the southeastern piney woods (51,993). Only 15 additional cities have populations greater than 20,000, which helps to contribute to Mississippi's relatively low population density of 61 persons per square mile (year 2000), 32nd in the United States.

/2014/ In 2012, the state population was 2,984,926, Jackson's population was 175,437, Gulfport's population was 70,113 and Hattiesburg's population was 47,169. The City of Southaven, which is a suburb of Memphis, TN, in northwest Mississippi, is now the state's third largest city with a population in 2012 of 50,374. //2014//

***/2015/ The 2013 state population estimate was 2,991,207, a 0.8 percent increase since 2010. //2015//***

Mississippi's physical features are lowland with the hilliest portion located in the northeast section of the state where the foothills of the Appalachians cross over our border. Woodall Mountain rises to 806 feet; however, the mean elevation for the entire state is only 300 feet. From east central Mississippi heading south, the land contains large concentrations of piney woods which give way to coastal plain features further on towards the Gulf Coast. Southwest Mississippi tends to be quite rural with significant timber stands.

The Mississippi Delta, technically an alluvial plain, lies in the northwest section of the state and was created over thousands of years by the deposition of silt over the area during repeated flooding of the Mississippi River. Exceedingly flat and containing some of the world's richest soil, the Delta is also rich in history. The blues, the forerunner of rock-and-roll, was initially sung by African-Americans who worked the cotton fields and experienced untold hardship and bleak circumstances. Many of the problems Mississippi experiences today are a direct result of our past and are difficult, but not impossible, to overcome.

The Delta is well known for its poverty and rural characteristics. Lacking in infrastructure necessary to support well paying jobs, the Delta tends to be primarily agricultural in nature with its concomitant lower paying jobs. Residents too often lack the financial resources to pay for health care and other necessities and may have to drive an hour or more to reach specialized and emergency health care services. While some improvements have occurred during recent years with the advent of casino gambling along the river, the growth of Viking Range Corporation in Greenwood (a high end manufacturer of kitchen equipment and appliances) and the opening of Interstate 69 through its northern portion, the Delta still remains quite poor and rural and still lacks in infrastructure such as four lane highways that are more common in other areas of the state.

The Appalachian Mountain foothills are a prominent geographic feature of northeast Mississippi and enter from the corner of the state that borders Tennessee and Alabama. As in much of Appalachia, northeast Mississippi tends to be heavily white, rural, and poor. Despite this, the area is home to the largest non-urban hospital in the country, North Mississippi Medical Center (NMMC), the health services entity of North Mississippi Health Services located in Tupelo, MS. NMMC provides services through a regional network of more than 30 primary and specialty clinics to 24 regional counties and their communities and is also the site of a family medicine residency clinic.

Tupelo is the largest city in northeast Mississippi with a 2008 population of just over 36,000. Toyota Manufacturing announced in early 2007 the decision to locate in nearby Blue Springs, MS, a \$1.3 billion auto assembly plant which was to directly employ 2000 workers and many others in support of this venture. After the recent downturn in the economy, Toyota indefinitely suspended operation of the plant until economic and automotive manufacturing conditions improved. As of April 2010, the plant stands built, but idle, with no immediate prospect for plant start up on the horizon. While not as desperate as the Delta, Appalachian Mississippi still experiences more than its share of hardship.

/2013/ Toyota Manufacturing near Blue Springs began production of automobiles in October 2011. //2013//

/2014/ Tupelo's population in 2012 was 35,490. //2014//

/2014/ Yokohama Tire Corp. has signed an agreement to build a \$300 million commercial truck tire plant in West Point in northeast Mississippi and expects to initially hire 500 employees. Future expansions could quadruple original employment levels. Construction of the plant is scheduled to begin in September 2013 and completed two years later, Yokohama said. (CBSNews.com, 4/29/13)

Natron Wood Products of Jasper, Oregon, will open operations in an existing 265,000 square-foot facility in Louisville in east central Mississippi. Natron is expected to invest \$10 million in the project that the company says will create more than 200 new jobs. (Clarion-Ledger Newspaper, 5/13/13) //2014//

Moving from west central to east central Mississippi along the Interstate 20 corridor, one encounters the cities of Vicksburg on the Mississippi River across from Louisiana, Jackson about 40 miles to the east, and Meridian about 20 miles short of the state line of Alabama. Central Mississippi has a population concentration higher than both the Delta and Appalachian Mississippi, although most of this population resides in the three cities mentioned above. In between lie vast expanses of open and forested land with agricultural operations the most prominent industry to be found. Between Jackson and Meridian, there are located poultry growers and processors that employ thousands of workers, including significant portions of the Latino population that resides in our state.

Meridian is home to Peavey Electronics, a globally recognized manufacturer of music equipment including amplifiers and guitars, and is also the site of the Meridian Naval Air Station which provides jet fighter training for the United States Navy. Jackson is host to the state's premier health care facilities including the University of Mississippi Medical Center, the state's only Level I Trauma/Tertiary Care facility, as well as the educational campuses of Jackson State University, Millsaps College, and Tougaloo College.

Southwest Mississippi includes some of the most rural areas of the state and has large tracts of timber. Natchez is the largest city in the region and is located in Adams County which has an unemployment rate of almost 12 percent. Nearby counties have unemployment rates that rise to almost 20 percent. With jobs hard to come by and the rural nature of the area, health care is

problematic for many.

The piney woods of southeast Mississippi are home to communities such as Hattiesburg and Laurel. Hattiesburg is home to the University of Southern Mississippi and Forrest General Hospital, a Level II Trauma Care facility that serves 17 counties in the region.

The Mississippi Gulf Coast is home to the largest concentration of people outside of metropolitan Jackson, with about 350,000 people in the three counties that actually touch the water, or about 12 percent of the state's total population. Anchored by Pascagoula, Biloxi, and Gulfport, the Gulf Coast is home to several large casino operations as well as Northrop Grumman Shipbuilding, one of the state's largest employers. Gulfport is also home to North America's premier yacht builder, Trinity Yachts, which annually delivers floating palaces that rival anything produced outside of the United States. It is ironic and sad that one has to drive only a few miles from the gates of Trinity to find poverty that stands in marked contrast to the company's glamorous products. While not nearly as true today as in the past, Mississippi still has much work to do to narrow the disparities that continue to exist despite improvement over the years.

Geography is an important tool for tracking health status indicators, including obesity. The Centers for Disease Control and Prevention released the first county-by-county survey of obesity that reflects past studies that show the rate of obesity is highest in the Southeast and Appalachia. High rates of obesity and diabetes were noted in 75 percent of Mississippi counties with the highest rates observed in Holmes, Humphreys, and Jefferson counties. Obesity rates in those counties were close to 70 percent higher than the national rate. Culture and poverty contribute to the high rates. Southerners love to eat greasy high fat foods and often lack the resources to afford healthier choices or lack access to gyms and safe jogging trails.

/2014/ A new report from the Robert Wood Johnson Foundation finds Mississippi leading in efforts to lower childhood obesity rates. Data collected between 2005 and 2011 shows a 13.3 percent overall decline in childhood obesity in Mississippi. A focus on higher nutritional standards in schools is being cited as a contributor to the decline. The report can be accessed at [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf401163](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401163). Another initiative cited in Mississippi as beneficial is the "Fruits and Veggies -- More Matters" program, which is presented to a variety of establishments, including offices and schools. //2014//

## Demographics

The racial composition of Mississippi residents is about 61 percent white and 37 percent African American according to the U.S. Census Bureau. Mississippi has the largest proportion of African-American residents of all the states. The immigrant populations, including non-citizens, continue to grow, as Latinos seek work in the poultry, forestry, and construction industries in the state. According to 2008 U.S. Census estimates, Latinos comprise 2.2 percent, or 64,650 people, of the state's population, an approximate increase of 60 percent from the year 2000.

/2012/ According to 2009 U.S. Census estimates, Latinos comprise 2.5 percent of the state's population. //2012//

/2013/ According to 2011 U.S. Census estimates, persons of Hispanic or Latino origin comprise 2.9 percent of the state's population. //2013//

**/2015/ According to 2012 U.S. Census estimates, persons of Hispanic or Latino origin still comprise 2.9 percent of the state's population. //2015//**

Mississippi demographics vary by race and ethnicity within the state according to location. Tishomingo County in the extreme northeast is 95 percent white while Jefferson County in the southwest portion of the state is 86 percent black. However, the percent of persons living below the poverty level in Tishomingo County is almost exactly half the rate of Jefferson County which is

illustrative of the many disparities that occur between the races throughout Mississippi. To provide another example, but at the state level, the percent of low birth weight newborns born to whites in Mississippi was almost half that of blacks in the state.

A relatively large Latino population is found in Scott County between Jackson and Meridian along the Interstate 20 corridor where close to 10 percent of the population is Latino. Scott County has significant poultry operations which require large numbers of laborers. Latinos, who fill significant numbers of these positions, tend to experience greater barriers to health care access which can in turn place a burden on local safety net health programs including Mississippi State Department of Health (MSDH) clinics. Efforts to develop cultural competency within the agency are discussed in III. D. Other MCH Capacity.

The Mississippi Gulf Coast has a Vietnamese population that has grown since the 1980s when they began to settle along the coastlines of Louisiana, Mississippi, Alabama and Florida after leaving their native country. Although they brought with them their fishing experience, many were not able to acquire new skills and have had a hard time learning the English language. MSDH, in an effort to reach this population with culturally sensitive health care messages, prints and distributes brochures in Vietnamese, including a pandemic influenza brochure that provides facts on how to protect individuals and families from becoming infected.

Following Hurricane Katrina in 2005, Vietnamese patient visits to MSDH clinics decreased as this population became displaced. Meanwhile, there has been a greater increase in the number of Latino patients being seen by the health department. The influx of Latino patients produced a need for Spanish interpreters, which have been obtained to assist in helping the Latino population, especially in Harrison and Jackson counties. Some patients are not able to read their own language, and the addition of interpreter assistance has been instrumental in helping meet their needs. Because of a lack of health insurance or knowledge of the health system, Latino women often present late in their pregnancy which increases risks related to prenatal care. Once the newborn is delivered, mothers and their newborns continue to be served through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Immunizations, and Family Planning clinics.

#### Socioeconomics

Mississippi faces enormous health challenges, with long-term social, educational, and economic problems linked to profound inequities in access to medical and dental care. Mississippi is the fourth most rural state in the nation and over 50 percent of the state's 2.9 million people live in areas classified as rural by the Census Bureau. In 2008, 21 percent of Mississippi's population lived at or below the federal poverty level, compared with 13 percent nationally. Mississippi also ranked 51st among states and the District of Columbia for median family income level (at \$37,790 compared to national figure of \$52,029). The poverty rate for children under age 18 was much higher at 38 percent compared to the national rate of 23 percent according to the Kaiser Family Foundation's State Health Facts.

//2012/ Because of federal budget cutbacks that take effect after May 31, 2011, the low-income parents of nearly 4,000 children will no longer be able to use federally funded vouchers that had paid some of their daycare and after-school care costs. The Mississippi Department of Human Services administers the voucher program and will lower the percent of the state median income that qualifying families can make and still be eligible for the program. Loss of the vouchers could force some families to choose between daycare and other family expenses including healthcare.  
//2012//

Those who live in poverty have increased risk for poor health outcomes, as demonstrated by CDC data that reveal that Mississippi leads the nation in obesity, cancer, heart disease, and infant mortality rates. Poverty, lack of education, geographical isolation and entrenched cultural norms contribute to a lack of access to health care and health disparities.

Personal incomes in Mississippi are the lowest in the nation. In 2007, personal income was \$28,845 according to the U.S. Census Bureau. In March 2010, Mississippi's unemployment rate stood at 11.1 percent. These statistics all add up to the fact that Mississippi is the poorest state in the country.

/2012/ According to the United States Bureau of Economic Analysis, personal income in Mississippi increased to just over \$31,000 in 2010, still last among all states. In May 2011, Mississippi's unemployment rate stood at 10.2 percent. //2012//

***/2015/ According to the United States Bureau of Economic Analysis, per capita personal income in Mississippi increased to just \$33,073 in 2012, 50th among all states. The unemployment rate as of March 2014 = 7.6 percent. (Rank: 46; Bureau of Labor Statistics) //2015//***

Because of our high level of poverty, Mississippi faces challenges more severe than those of other states when it tries to craft policies to help low-income families. The state relies on a regressive tax system to generate revenues, with a high sales tax and a low income tax compared to national averages. The proportion of the state health department's Office of Health Services budget that is derived from state funding is less than two percent; Mississippi, therefore, relies heavily on federal funding sources to augment its budget. (The Office of Health Services encompasses Maternal & Child Health, Women's Health, WIC, Oral Health, Health Data & Research, Tobacco, and Preventive Health)

Concurrent with the rest of the nation, the economic downturn and recession has taken a toll on Mississippi. As unemployment has increased and business has declined, state revenues dropped well below predictions resulting in budget reductions across all state agencies and further decreases in access to needed services. MSDH and other state agencies are under the threat of personnel reductions and furloughs. At the same time, demand for health care provided by safety net organizations such as community health centers and MSDH clinics has increased. With stimulus funding expected to wind down within the next year or two, those without access to health insurance face increased risks in overcoming current health care access barriers.

#### Health and Health Care Access

Mississippi is ranked last among all states for overall health care according to the Commonwealth Fund. Mississippi ranks 49th for access and prevention and treatment, 45th for avoidable hospital use and costs, 46th for equity, and last for healthy lives. Mississippians, including our children, are routinely ranked as the fattest in the country and we lead the nation in high blood pressure, diabetes, and adult inactivity. The Delta region is at even greater risk for health problems because of lack of accessibility and availability of medical care. An estimated 60 percent of residents live below the poverty level here.

In 2009, Mississippi Kids Count held its second annual summit at which the 2008 Mississippi KIDS COUNT Data Book was released. Data findings showed that Mississippi still ranks at or near the bottom of most major indicators of children's well-being. The latest data available from the Kids Count Data Center at the Annie E. Casey Foundation showed that Mississippi ranked 47th of 50 states in births to females 15-17 years of age, 49th in child death, and 50th in low birth weight, infant mortality, and overall rankings among all states. Adequate and stable Title V MCH funding is critical to improve the health indicators underlying these rankings and to move the health of Mississippi's children off the bottom of national state listings.

/2012/ The latest data available from the Kids Count Data Center at the Annie E. Casey Foundation show that Mississippi ranks 48th of 50 states in births to females 15-17 years of age (2008) and 50th in child death (2007), low birth weight (2008), infant mortality (2007), and overall rankings among all states (2010). //2012//

/2014/ The latest Kids Count data show Mississippi 50th in state rankings in births to teenagers 15-19 years (rate/1000 females, 2010), tied for 48th in deaths to children 1-14 years (2010), 50th in low birth weight babies (<2500 grams, 2010), 50th in infant mortality (2010), and 50th in the Kids Count Overall Rank (2012). //2014//

***/2015/ In 2013, Mississippi was ranked 48th in the health category of the KIDS COUNT state ranking of child well-being. Compared to last year's ranking, Mississippi had a smaller share of uninsured children, lower teen deaths, and fewer teens abusing alcohol or drugs. The improvement in the health of Mississippi's children has helped the state to move out of the 50th into the 49th spot in overall well-being for the first time in the 24-year history of the ranking. //2015//***

There is a movement in this country towards preventive health services rather than after the fact treatment which tends to inflate health care costs that are already beyond the reach of many in Mississippi, including much of the MCH population. The MSDH understands the importance of prevention, especially in an era of shrinking state health care budgets, and emphasizes programs that prevent disease in order to reduce morbidity and mortality and decrease costs.

The MSDH Office of Preventive Health's (OPH) mission is to educate, prevent and control chronic diseases and injury by promoting optimal health through advocating for community health awareness, policy development, coordinated school health, and faith-based and worksite wellness initiatives. The OPH also collaborates with public, private and voluntary organizations; establishes and participates in coalitions, task forces and partnerships; and obtains funding for planning and program development.

Examples of preventive programs and services provided by the MSDH or its partners through a collaborative process that target our MCH population include children's immunizations, infant mortality reduction interventions [Delta Infant Mortality Elimination/Metropolitan Infant Mortality Elimination (DIME/MIME) projects], the placement of dental sealants on children's teeth, the fluoridation of public water supplies, smoking cessation programs for pregnant women, and children's nutrition information.

/2012/ MSDH clinics continue to be a major provider of EPSDT preventive health screenings for infants/children, which includes lead screening. //2012//

Additional areas of emphasis and their priorities are listed below:

- 1) Cardiovascular Health Program priorities are to: control high blood pressure, educate on signs and symptoms, improve emergency response, eliminate health disparities, develop culturally competent strategies for priority populations and develop population-based strategies;
- 2) Comprehensive Cancer Control (CCC) Program priorities are to: establish a statewide system for comprehensive cancer control in Mississippi, develop a coordinated response to the excessive cancer burden in Mississippi using data and input from interested citizens and to identify and prioritize the implementation of the state CCC plan;
- 3) Diabetes Prevention Program priorities are to: identify and monitor the burden of diabetes, develop new approaches to reduce the burden of diabetes, implement specific measures, and coordinate and integrate efforts to reduce the economic and social consequences of diabetes;
- 4) Community Health Program priorities are to: promote population based strategies to impact policy and environmental changes that will positively affect the risk factors of chronic disease;
- 5) Injury/Violence Prevention priorities are to: promote bicycle/pedestrian safety awareness, provide bicycle/pedestrian training to key stakeholders, reduce the incidence of death and injuries attributed to fires in high risk communities, enhance infrastructure for injury prevention and control in Mississippi, and promote injury prevention policy.

Access to MCH services is impacted by Mississippi's in-person (face-to-face) Medicaid/SCHIP recertification requirement which is considered a barrier to enrollment and recertification and may

be partially responsible for the over 50,000 children dropped from Medicaid/SCHIP rolls. The State of New York's decision to eliminate face-to-face recertification for all Medicaid/SCHIP beneficiaries leaves only Mississippi with this requirement. In an effort to improve access to Medicaid/SCHIP services, the Mississippi House and Senate passed versions of a Medicaid technical amendments bill during the 2009 session with a provision that would end face-to-face recertification for children 16 years and under. The bill died in conference and was not revisited in 2010; the result is that Mississippi is still the only state with the face-to-face recertification requirement.

/2012/ See the MississippiCAN initiative under Medicaid later in this section. //2012//

Because of Mississippi's rural nature and uneven distribution of physicians, geographic disparities exist in access to primary care services. According to Kaiser's State Health Facts 2008 data, over 900,000 Mississippians, or almost 32 percent of the population, live in areas designated as Primary Care Health Professional Shortage Areas. This is close to three times the percentage for the United States. The American Academy of Family Physicians in 2007 ranked at least seven out of ten Mississippi counties as health professional shortage areas (HPSAs) for family physicians. Trust for America's Health listed 110 primary care HPSAs and 103 dental HPSAs in 2009; however, all of Mississippi's 82 counties contain Designated Medically Underserved Areas as defined by the federal Health Resources and Services Administration (HRSA). HPSAs focus solely on provider shortages whereas Designated Medically Underserved Areas incorporate infant mortality and poverty rates and the number of elderly within the area.

/2014/ Kaiser Family Foundation 2012 data show over 1.6 million Mississippians, about 54 percent of the population, live in areas designated as Primary Care Health Professional Shortage Areas. Trust for America's Health listed 107 primary care HPSAs and 108 dental HPSAs as of 12/31/12. All of Mississippi's 82 counties continue to contain Designated Medically Underserved Areas as defined by HRSA. //2014//

***/2015/ Mississippi still has 107 primary care HPSAs and 108 dental HPSAs as of 7/29/13. A HRSA website search on 4/25/14 showed all of Mississippi's 82 counties continue to contain Designated Medically Underserved Areas as defined by HRSA. //2015//***

#### Primary Care in Mississippi

Primary care is the ideal entry point for health care as opposed to emergency care provided at local hospitals. Additionally, without a primary care provider, there is no medical home. It is in the medical home that prevention is emphasized and expensive emergency care is headed off before it becomes necessary. Unfortunately, too many Mississippians lack affordable access to primary health care either because of a lack of personal resources to pay for the care, lack of employer provided insurance coverage, transportation to primary care providers, or a lack of providers who accept public insurance such as Medicaid. This is in addition to large swaths of our state that lack adequate health care of any kind and that is referenced above in the section on HPSAs. Mississippi is working to overcome these significant barriers to primary care using a variety of means, some of which are described in the following narrative. Examples are also given that demonstrate just how difficult these barriers are to overcome.

MSDH -- The Mississippi State Department of Health is the autonomous Title V agency for the state of Mississippi. Unlike some other states that may have multiple public health departments, MSDH serves the entire state. For more on MSDH, please see the Agency Capacity section below within the MCH Block Grant.

The University of Mississippi Medical Center -- UMC, as it is referred to locally, is located in Jackson and is the state's only academic health science center. Schools of medicine, nursing, dentistry, health related professions, graduate studies and pharmacy are either housed at UMC or offer classes on campus (pharmacy is headquartered in Oxford, Mississippi, the home of the

University of Mississippi). University Health Care offers the only Level I Trauma facility and the only Level III neonatal intensive care nursery in the state.

As a taxpayer supported institution, UMC is a leading provider of unreimbursed health care and an important part of the public safety net in central Mississippi. James Keeton, M.D., Vice-Chancellor for Health Affairs and Dean of the School of Medicine, emphasizes four missions: education, research, patient care, and the elimination of health disparities in Mississippi. To accomplish the fourth, UMC has partnered with MSDH, Federally Qualified Health Centers, and hospitals in Pascagoula, Meridian and Hattiesburg. The DIME project cited earlier in this section is an example where UMC and MSDH have partnered to reduce disparities by targeting an area of the state prone to such disparities: the Mississippi Delta. DIME targets high-risk women in the Delta that have given birth to a very low birth weight infant, a category that happens to be mostly African-American, for interventions, including basic primary care prevention services, that are intended to prevent future very low birth weight occurrences. More on DIME, and its sister project, MIME, is found in Section III. B., Agency Capacity.

Schools of Nursing -- More than 15 schools of nursing operate in Mississippi. As in other states, nurses are an important health care delivery vehicle that provide cost effective access to primary care medical services and serve as a stop gap for the physician shortage. While the new health care reform law is expected to provide health insurance coverage to more than 500,000, there must be an adequate number of providers to assure access. Unfortunately, there is a growing nursing shortage in the state that is unlikely to improve in the near term. The shortage rate is highest in the rural areas including the Delta where the vacancy rate reaches 20 percent, precisely where some of the greatest need exists. Without greater capacity in the state's nursing school faculty, class sizes will continue to be limited because of required student-teacher ratios. Meanwhile, with the average nurse's age being 55 and nursing faculty averaging 57 years, nursing shortages will continue to exist for the foreseeable future.

/2012/ A bill to delete a regulation that requires advance practice nurses, including nurse practitioners, midwives and certified registered nurse anesthetists, to enter into a collaborative agreement with a physician located within 15 miles died during the 2011 legislative session. Several doctors spoke in opposition to the change, while the nurses argued it would promote business and improve access to health care. //2012//

Physician Shortage -- The new health reform law passed earlier this year by Congress encourages preventative care through primary care physicians. A problem which will have to be overcome is Mississippi's doctor shortage, already the worst in the nation. Mississippi has 63.8 active primary care physicians for every 100,000 people compared to the national average of 89.6 according to the Association of American Medical Colleges. Dr. James Keeton of UMC says with more people covered, access will be a problem. The medical school would like to increase class size, but funding to do so is problematic in an era of shrinking state budgets.

***/2015/ According to a 2/25/14 Clarion-Ledger (Jackson, MS) article by Sid Salter, a study conducted by researchers at Mississippi State University's Social Science Research Center determined that "With the gradual rollout of the Affordable Care Act, the projected influx of subsidized health insurance recipients has raised many concerns that doctors' offices will not be able to meet the overall demand for medical services." Key findings include that having health insurance does not equate to access to primary health care in Mississippi and up to half of primary care physician offices in Mississippi are not currently accepting new Medicaid patients. The study's authors speculate that existing reimbursement rates as well as administrative burdens are partially to blame for the relatively low acceptance of government-funded health insurance recipients by physician's offices. //2015//***

/2013/ Mississippi has 63.6 active primary care physicians for every 100,000 people compared to the national average of 90.5 according to the Association of American Medical Colleges. //2013//



/2014/ The state has 159 doctors per 100,000 people, the lowest in the nation. One factor is the number of patients without health insurance, just more than 19 percent (44th of 50 states) according to America's Health Rankings 2012 Annual Report (United Health Foundation). Recent legislation, the Healthcare Zone Act, allows medical zones to be established throughout the state and provides tax incentives to promote the growth of the health care industry in Mississippi. The legislation created a business incentive program, known as the Mississippi Health Care Industry Zone Incentive Program, to encourage health care-related businesses to locate or expand within a qualified Health Care Zone in the state. //2014//

To help counter one aspect of the physician shortage, the uneven distribution of primary care providers within the state, the Mississippi Legislature created the Mississippi Rural Physicians Scholarship Program in 2007 to encourage more UMC students to become primary care physicians in rural areas. Students who agree to serve in a primary care specialty in a rural area get \$30,000 a year to complete their training. This program, along with funding to enlarge the medical school physical plant and hire additional faculty, are required to begin to ease the doctor shortage going forward.

/2013/ The following narrative in quotation marks and additional information on the Mississippi Rural Physician's Scholarship Program (MRPSP) can be found on their website at <http://mrpsp.umc.edu/>. "To jump start the flow of primary care physicians in the health care pipeline in 2008, ten UMMC School of Medicine students were awarded state funded scholarships valued at \$30,000 for 2008-2009. The number doubled in 2009-10. Ten more were added in 2010-11 and another 10 in 2011-12. With continued strong legislative support in 2012, MRPSP will award 1.5 million in state funded scholarship. This fall 54 medical students will each receive \$30,000 for their studies in medical school through the combined resources of the Mississippi Legislature, the Medical Assurance Company of Mississippi, the Selby and Richard McRae Foundation and the Madison Charitable Foundation for a total of \$1,620,000.00." //2013//

/2014/ The MRPSP channels scholars into five primary care specialties (Family Medicine, Obstetrics and Gynecology, Pediatrics, Medical Pediatrics or General Internal Medicine) that will target the current rural physician shortage. According to the program website, <http://www.umc.edu/mrpsp/>, there are 12 scholars in the class of 2013, 11 scholars in the class of 2014, 14 scholars in the class of 2015, and 17 scholars in the class of 2016. //2014//

Osteopathy -- Schools of osteopathic medicine have traditionally emphasized training physicians who specialize in primary care. The majority of these schools have a mission statement whose purpose it is to produce primary care physicians who emphasize health education, injury prevention, and disease prevention. Osteopathic physicians consider the impact that lifestyle and community have on the health of each individual, and they work to break down barriers to good health. Osteopathic medicine also has a special focus on providing care in rural and urban underserved areas, areas where greater disparities tend to exist.

In Hattiesburg, Mississippi, William Carey University obtained provisional accreditation and established in 2008 the College of Osteopathic Medicine, the state's and region's first such school. Enrollment is ongoing and the first class is expected to start August 16, 2010. Authorized in 2007 by the Board of Trustees at William Carey University, the rationale was to "address the severe shortage of physicians in Mississippi and surrounding states and to impact the healthcare of rural Mississippians."

/2012/ The first class enrolled in August 2010. //2012//

***/2015/ William Carey University College of Osteopathic Medicine graduated its first class of medical students (94 students) as DOs in May 2014 and also officially obtained its full accreditation from the American Osteopathic Association's Commission on Osteopathic College Accreditation. //2015//***

## Immunization Program

MCH supports the provision of immunizations designed to eliminate morbidity and mortality due to childhood vaccine-preventable diseases such as diphtheria, tetanus, pertussis, polio, measles, influenza, and pneumonia in all MSDH. The program goal is to increase immunization rates throughout the lifespan for children, adolescents and adults. Services include vaccine administration, monitoring of immunization coverage levels, disease surveillance and outbreak control, information and education, and enforcement of immunization laws.

The Immunization Program collaborates with Mississippi Division of Medicaid to ensure accurate and timely reimbursements for the Vaccines for Children Program. In addition, the program maintains a Memorandum of Understanding Agreement to reimburse the agency for vaccines purchased through the SCHIP Program. The Program also works closely with the American Academy of Pediatrics and the American Academy of Family Physicians to educate and inform providers about vaccines. Dr. Sandor Feldman is the Immunization Consultant for the Immunization Program.

Other collaborations occur with the MS Department of Education, MS Private School Association and the MS Catholic Dioceses to ensure that all children enrolled in Mississippi schools are vaccinated according to the MS Code of 1972, SEC. 41.23.37. Immunization practices for control of vaccine preventable diseases: attendance by unvaccinated children. The program conducts immunization workshops, distributes memoranda/letters when changes occur, and prompts school administrators of immunization requirements. Staff also partner with Head Start and child care center directors to ensure students attending their programs are fully immunized.

The 2008 percent of children 19-35 months who were immunized is 77, only one percent less than the United States average according to Kaiser State Health Facts for Mississippi, and should continue improving because of the development of a statewide immunization registry and outreach campaign. Other measures of child health and well-being are less encouraging. Compared with the nation as a whole, a greater percentage of children in Mississippi are born out of wedlock and live in single parent households. According to the 2008 Kids Count data, Mississippi ranks 50th of the 50 states in births to females aged 15-19 years. According to this same source, Mississippi had the highest percentages of low birth-weight babies, ranked 50th in infant mortality, 47th in child death rates, and 44th in teen deaths by accidents, homicide, and suicide. Mississippi, overall, was ranked last among the states in a composite rating of 10 selected measures of child well-being. However, despite these negative indicators, Mississippi is working diligently to incorporate several initiatives and/or programs aimed at addressing the risk factors that affect pregnant women, infants, children, adolescents, and children with special health care needs (CSHCN) in our state.

//2012/ The percent of children 19-35 months who were immunized during the 2008-2009 year was 81.1 according to the National Immunization Survey which exceeded the national average and resulted in Mississippi achieving the rank of number one in the country. The Mississippi State Department of Health gives about 40 percent of all childhood vaccinations in the state. //2012//

//2014/ Currently, the Immunization Program, located in the Office of Communicable Disease, provides vaccine to approximately 520 private physicians and community health centers that are enrolled as Vaccine for Children providers. //2014//

## Oral Health

While many tend to separate oral health from overall health, it is important to understand that people are not healthy without good oral health. As with other areas of health, Mississippians suffer from worse oral health compared to the rest of the country. Mississippi also restricts the practices of dental auxiliaries such as dental hygienists which could serve to meet the oral health

care needs of rural Mississippians. State laws require services provided by dental hygienists be under the direct supervision of a dentist with the singular exception that hygienists in the employ of MSDH or in public schools may provide hygiene screening and instruction under general supervision. Direct supervision would prevent the dental hygienist from providing dental care in a rural area unless a dentist was able to provide direct supervision. It is a fact that most dentists, like other health care providers, tend to work in the more heavily populated urban/suburban areas of the state.

/2013/ In response to the immense oral health needs of the state, the MS State Department of Health, Oral Health Program, provides essential services to address oral health needs statewide. The mission of the oral health program is to promote oral health, prevent oral diseases, and assure access to quality oral health care. Much of the State Oral Health Program's (SOHP) preventive efforts include implementing community water fluoridation, providing dental sealants to elementary school children, and administering fluoride varnish in child care centers. The program also participates in nutrition and oral health education for clients participating in the WIC program. //2013//

***/2015/ The fluoride varnish program early childhood caries prevention efforts include training medical providers to perform oral health screenings and provide fluoride varnish applications. //2015//***

/2012/ CSHCN, particularly those with cleft lip/palate, are impacted by the lack of providers who accept Medicaid for the specialty services required for treatment of these special needs children. MCH funds are utilized to improve access to needed services for this population. CMP has also begun discussion with Medicaid to determine if CMP can serve as a pass through for reimbursement for those dental providers who elect not to become Medicaid providers but agree to serve CMP enrollees for specialized dental services. //2012//

The SOHP is collaborating with the Mississippi Head Start Association and the American Academy of Pediatric Dentistry to implement the Head Start Dental Home Initiative to create networks of dental providers capable of providing a full range of oral health services for children. The SOHP is also working with the Division of Medicaid and the Mississippi Chapter of the American Academy of Pediatrics to determine the feasibility of implementing a physician reimbursement for oral health prevention to increase the number of children who receive this care at well-child visits.

MSDH Mobile Dental Clinic (Direct Health Care) - In January 2007, the Sullivan-Schein Corporation donated a 51-foot mobile-dental-clinic equipped with two dental operatories, digital radiography, and electronic records for use to provide direct health care services. In February 2008, we collaborated with the University of MS School of Dentistry to provide free dental care to about 50 people in the City of Clarksdale in the MS Delta. We continue to seek additional funding to use this state-of-the-art mobile clinic to provide dental services in rural underserved communities.

#### Community Health Centers

Mississippi's 21 community health centers, like MSDH, provide gap-filling direct medical services in all areas of the state. The Mississippi Primary Health Care Association (MPHCA) represents the interests of the state's community health centers in an effort to improve access to health care for the medically underserved and indigent populations of Mississippi. Essential to continuing their mission, federal funding such as Medicaid and SCHIP is required for the continuation of the provision of medical care to the underserved populations in Mississippi served by each center. To this end, HRSA, in an effort to address increased demand coupled with reduced access, released over \$300 million in economic stimulus monies from the federal American Recovery and Reinvestment Act to the nation's community health centers, with Mississippi receiving over \$6 million. This money is estimated to create additional service capacity to over 45,000 new patients

and 22,000 new uninsured patients in Mississippi's community health centers. Patients who visit community health centers are less likely to require hospitalization and visits to the emergency room which results in health care cost savings according to HRSA. The MSDH Title V Program collaborates with state community health centers individually and through the MPHCA.

## Insurance Reform

Providers in Mississippi currently lose over \$800 million in bad debt which is passed on to paying patients in the form of higher premiums and charges. The following narrative includes statistics from Congressman Bennie Thompson's congressional website that highlight the difficulty many in Mississippi experience daily in accessing affordable health care. Health insurance premiums in this state have risen 89 percent since the year 2000. Roughly 1.4 million people in Mississippi get health insurance on the job, where annual family premiums average \$11,303. However, 20 percent of people in Mississippi are uninsured, and 60 percent of them are in families with at least one full-time worker. Fourteen percent of middle-income Mississippi families spend more than 10 percent of their income on health care. Eighteen percent of people in Mississippi report not visiting a doctor due to high costs. Mississippians with employer coverage declined by ten percent from 2000-2007. While small businesses make up 72 percent of Mississippi businesses, only 28 percent of them offered health coverage benefits in 2006 -- down 8 percent since 2000.

Until the full effects of the new health reform legislation occur in 2014, the United States Department of Health and Human Services (HHS) has proposed a temporary high risk pool program that provides \$5 billion to legal residents in order to assure health care coverage with affordable premiums. Mississippi's proposed share of this funding is \$47 million. The state insurance commissioner has notified HHS that, although Mississippi does not have a state agency high risk pool, it does have a statutorily established high risk health pool which derives funding from assessments on health insurance companies. Mississippi will opt out of the federal temporary program as a state entity because of concerns that it would become an unfunded mandate if the federal funds are not sufficient. [The Centers for Medicare and Medicaid Services (CMS) actuary estimates that the \$5 billion may be exhausted by 2012 and perhaps as early as 2011.] As a result, Mississippi will be a federal fallback state along with approximately seventeen other states.

***/2015/ Mississippi chose not to expand its Medicaid program. Because the Patient Protection & Affordable Care Act (ACA) envisioned low-income people receiving coverage through Medicaid, people below poverty are not eligible for Marketplace subsidies. Thus, some adults in Mississippi fall into a "coverage gap" of earning too much to qualify for Medicaid but not enough to qualify for premium tax credits. In Mississippi, 138,000 uninsured adults (30 percent of the uninsured in the state) who would have been eligible for Medicaid if the state expanded fall into the coverage gap. Because they do not gain an affordable coverage option under the ACA because of incomes that fall below the poverty line, which Medicaid expansion was to have covered, they are most likely to remain uninsured. (KFF.org-Jan 2014) //2015//***

## Medicaid

The Mississippi Division of Medicaid, a component of the Governor's Office, provides an invaluable safety net for the state's most vulnerable population. But because of recent shortfalls in the state budget, the Division of Medicaid has stated its intention to cut reimbursement rates for the last quarter of the current fiscal year to doctors, dentists, and other providers pending federal approval. Payment cuts could range from 15-20 percent. The Governor advocates a more cautious spending of stimulus funding and so called rainy day reserves to maintain a balance for future lean years while lawmakers advocate their current use to prevent providers from declining to participate in the program because of low reimbursement rates. Mississippi already struggles to provide reimbursement rates that adequately cover the cost of providing services in the private sector. Regardless of the outcome, the latest funding crisis comes on the heels of years of similar

funding shortfalls which serve to demonstrate the importance of health care reform for Mississippi.

/2012/ The state's FY12 budget that recently passed is over \$200 million below the state's FY08 budget and reflects the lasting effects of the recession and slow recovery and the end of ARRA funding. State funding for Medicaid dropped 24 percent from FY11 but will realize an overall increase because of an increase in federal funding according to the MS Economic Policy Center. Future federal funding is in jeopardy because of increased pressure at the federal level to drastically cut spending in order to tame federal deficits and the debt. //2012//

Medicaid Utilization Data -- Mississippi's poverty levels would seem to dictate that our population's use of Medicaid would be higher than the rest of the country. Data provided by Kaiser's State Health Facts bears this out. Average annual growth in Medicaid spending between 1990 and 2004 outpaced other states' rates while Medicaid enrollment as a percent of the population is 35 percent higher than the national percent. Meanwhile, Mississippi just meets the national average on Medicaid dental utilization, with 38.1 percent of Medicaid enrolled children using dental services in 2007, the latest year for which data are available. Births paid for by Medicaid as a percent of total births are 50 percent higher in Mississippi than the rest of the country. As it is, Mississippi's general funds allocated to Medicaid are roughly one third the amount the rest of the country spends. Without future adequate and stable funding, Mississippians who depend on Medicaid may be faced with the prospect of denied care.

/2012/ The Mississippi Coordinated Access Network, or MississippiCAN, began on January 1, 2011, and is a new statewide plan meant to improve the health of thousands of Mississippi's most vulnerable Medicaid patients while saving the state money. Under this managed-care system, the motivation is furnished by an offer of gifts or other rewards to eligible recipients already on Medicaid who undergo certain health screenings, lead healthier lives and/or see their primary-care doctor soon after signing on. Those who qualify for MississippiCAN include Medicaid recipients who are aged, blind and disabled; have a disabled child at home; children in foster care; and those who are part of the state Department of Health's breast and cervical cancer program. The program is voluntary; those who enroll will continue to receive all their other Medicaid benefits.

In theory, with the focus on prevention and patient education, the state will save money because healthier Medicaid patients will have quicker access to appropriate care which should cut down on expensive emergency-room visits and unnecessary hospital admissions according to plan proponents. The plan requires no co-payments. It also loosens Medicaid restrictions on such services as the number of eye exams and prescription eyewear per year. The major expansion, however, is for office visits, which were limited to twelve per year. Now, for MississippiCAN enrollees, there are no limits.

However, a number of barriers to successful implementation have been identified during the initial phase. Families of CSHCN have not understood how the MississippiCAN system operates. Many families do not understand which services will or will not be covered in order to decide if they will opt out of the plan. Provider recruitment is also an issue since many providers have not selected to be a network provider in one of the two coordinated care organizations that provide services.

/2014/ Unfortunately, there continue to be reports from parents/families of barriers and complaints with the Mississippi Coordinated Access Network, or MississippiCAN. State health care advocates work with patients and families to navigate the application process and health care delivery system. //2014//

Mississippi is now one of 36 states offering some type of managed-care system for some or all of their Medicaid clients. //2012//

***/2015/ Medicaid Family Planning Waiver Project***

***The primary objective of this demonstration project is to reduce the number of unintended pregnancies and subsequent births paid by the Division of Medicaid. Project success is supported by the following data: increase in the number of women receiving family planning services through the waiver from 2004-2013; savings of over \$450 million since 2004; and a drop in repeat births for women accessing family planning waiver services for most age groups with significant decreases among teens. The project continues with one proposed change per guidance from the Centers for Medicare and Medicaid Services: include eligibility for men ages 13-44 capable of reproducing, with income no more than 185 percent of the federal poverty level for household size and not otherwise enrolled in Medicaid, Medicare, CHIP or other creditable health insurance. //2015//***

#### MSDH Service Prioritization Process

Mississippi's priorities are driven in large measure by our high levels of poverty found throughout the state. Those who live in poverty tend to find it more difficult to access health care services. As a significant provider of safety net health care, MSDH tends to invert the conceptual framework for the Title V MCH Block Grant, the MCH Pyramid, and emphasize the provision of direct health care at the expense of infrastructure building services. This inversion reflects the reality found in Mississippi that demands gap filling basic health services where such services otherwise would not or could not exist.

#### Mississippi Initiatives to Improve Health

The Mississippi Legislature passed last year, and the Governor signed into law, a fifty-cents-per-pack cigarette tax increase which is expected to reduce tobacco use and save lives. Estimates show that youth smoking will decrease 8.5 percent which means that 16,000 children will be prevented from becoming addicted adult smokers. Additionally, close to 10,000 current smokers are expected to quit and 7,600 Mississippians will be saved from smoking related deaths. Tobacco use is cited as the leading preventable cause of death in the United States according to the Centers for Disease Control and Prevention and is thought to be a leading cause of preventable death in Mississippi. It is hoped that the increase in Mississippi's cigarette tax will help the MSDH to decrease the number of current smokers, prevent our residents from starting smoking, and reduce the number of people that die each year from smoking related illnesses.

/2014/ Cigarette consumption fell to 67.9 packs per person in Mississippi in 2011. From 2008 to 2011, the sale of cigarette packs in Mississippi decreased by more than 26 percent. Both trends, experts say, can be partially attributed to 2009's increase in cigarette taxes. //2014//

***/2015/ Bills to prohibit smoking in public, enclosed locations with exceptions for certain businesses were introduced. A public hearing was held on the issue; however, SB 2171 & HB 656, relating to prohibition of smoking in all public places, and SB 2607 & HB 739, relating to enacting the Mississippi Smoke-free Air Act of 2014 died on February 4th.***

***HB 1250, a bill to increase the excise tax on cigarettes, died in committee on 2/26/2014.***

***The MSDH OTC partnered with the Substance Abuse and Mental Health Services Administration, the Smoking Cessation Leadership Center, and the Institute for Disability Studies at the University of Southern Mississippi to develop a strategic plan that will address nicotine addiction among behavioral health consumers and staff. The intent is to identify tobacco-related disparities among mental health patients and to create an environment of collaboration and cooperation among the fields of public health, mental health, and addictions.***

***In FY 2013, the MSDH OTC continued its partnership with the MS Department of Corrections (MDOC) to provide technical assistance and training to healthcare providers***

***at MDOC facilities on implementing a tobacco-free policy. The OTC coordinated trainings for MDOC healthcare providers on implementing tobacco cessation interventions with the offender population and provided trainings for MDOC staff on the dangers of tobacco use, the benefits of not using tobacco, and making referrals for tobacco dependence treatment services.***

***In FY 2013, the MSDH OTC continued its partnership with MDOC to provide technical assistance and training to healthcare providers at MDOC facilities on implementing a tobacco-free policy.***

***In FY 2013, the MSDH OTC partnered with the Department of Mental Health to provide trainings to healthcare providers on tobacco dependence treatment and referrals for mental health and substance abuse patients. //2015//***

#### Mississippi Health Advocacy Program (MHAP)

Funding provided by the W.K. Kellogg Foundation of Battle Creek, Michigan, has enabled the MHAP to offer a consumer assistance program to help parents navigate the bureaucracy that determines the often confusing eligibility requirements for Medicaid and SCHIP. Entitled Health Help for Kids, the program presents via telephone and internet the latest Medicaid/SCHIP information as well as counseling and representation on behalf of parents working with the Division of Medicaid to obtain needed benefits for their children. MHAP is a non-profit entity that provides research, analysis and grass-roots organizing to improve health policies, practices and funding in Mississippi.

#### Pregnancy Risk Assessment Monitoring System (PRAMS)

MS PRAMS is part of a CDC initiative to reduce infant mortality and low birth weight deliveries in Mississippi through the identification and monitoring of selected maternal experiences and behaviors including unintended pregnancy, prenatal care, breastfeeding, smoking, drinking, and mother and infant health. It is an ongoing, population-based, state-specific source of information that occurs postpartum and during a child's early infancy.

Since the start of data collection, PRAMS continues to successfully survey approximately 1200 mothers per year throughout the state of MS. The state's response rate is required to be 65 percent of the total sample size as the epidemiologically valid threshold.

*/2014/ An oversample of non-white women in Coahoma, Harrison, Hinds and Sunflower counties was added to evaluate Kellogg-funded interventions in the state. Changes were made in PRAMS staffing, the survey book, sampling, incentives and data collection due to new funding opportunities from the W.K. Kellogg Foundation. PRAMS now surveys about 3,000 mothers since adding questions exclusively for teenage mothers. //2014//*

***/2015/ Changes were made in staffing, IRB was modified for Kellogg oversampling, and an Appendix AA for Alternative Methods was developed. PRAMS anticipates CDC IRB approval for Appendix AA to implement the Alternative Method with community partners. PRAMS continued development of state and local partnerships, explored targeted incentives/rewards via focus groups and promoted PRAMS at numerous health fairs which enhanced PRAMS outreach activities. The new survey design has been field tested along with PRAMS publicity with community involvement. //2015//***

PRAMS data have been submitted to CDC for the years of 2003, 2004, 2006, 2007 (not weighted), and 2008. Data collection was halted in 2005 due to Hurricane Katrina. Surveillance Reports were published for the 2003 and 2006 analyzed data. Data have been analyzed for 2008 and is due for publication in late 2011.

/2014/ Data have been submitted to CDC for the years 2009, 2010 and 2011. PRAMS analyzed data for 2008 is online but is not yet available in hardcopy (Surveillance Report). MS will use the newly implemented PRAMS Integrated Data Collection System (PIDS) for collecting data in the telephone phase of the project to achieve specific goals. MS PRAMS continues to collect population-based data via the new Phase VII questionnaire. The Phase VII questionnaire launched in September 2012 and includes new questions with a new survey cover. An incentive is included with the first mailing of the questionnaire. An oversample of teen mothers less than 20 years old was added to increase the number of teen mothers sampled and collect data for valid representation of this age group. //2014//

***/2015/ PRAMS analyzed data for 2008 and 2009 is online but unavailable in hardcopy (Surveillance Report). The 2010 Surveillance Report has been developed but is unavailable online. Data have been submitted to CDC for 2012. MS PRAMS continues to collect population-based data via the Phase VII questionnaire. //2015//***

/2013/ Surveillance Report will be publicly available in 2012. Presentations using MS PRAMS data were made at the 2010 PRAMS National Conference, 2011 Maternal and Child Health Epidemiology National Conference, and 2011 American Public Health Association National Conference. PRAMS data utilization for Chronic Disease Prevention is currently being evaluated by a National Association of Chronic Disease Directors project. //2013//

The PRAMS Program is currently collecting data in Phase VI, while preparing some changes for Phase VII which will begin in 2012. PRAMS data have been used by researchers and for the following reports and programs: MS Infant Mortality Task Force Infant Mortality Trend Report, 2010 Legislative Infant Mortality Report, Mississippi National Children's Study Sampling Strategy, and the MS Tobacco Control Advisory Control Council Program. Presentations were given at the 2008 MCH EPI Conference and two publications were published: (1) a multiple state PRAMS data analysis on pre-pregnancy BMI/gestational weight gain and (2) "Prenatal Care Utilization in MS: Racial Disparities and Implications for Unfavorable Birth Outcomes."

/2014/ MS PRAMS data was used in the 2012 data book produced as a collaborative effort of the Region IV Network for Data Management and Utilization project and which includes the following organizations: The Cecil G. Sheps Center for Health Services Research at The University of North Carolina at Chapel Hill; the Maternal and Child Health, Family Planning, and Women's Health Program Directors at the U.S. Department of Health and Human Services (USDHHS) Region IV Office; and the Maternal and Child Health, Family Planning, and Women's Health Programs and the state statistical agencies in each state in USDHHS Region IV.

Presentations using MS PRAMS data were made at the 2012 PRAMS National Conference and Maternal and Child Health Epidemiology National Conference. Publications include the following: Consensus in Region IV: Women and Infant Health Indicators for Planning and Assessment, WIC Participation and Breastfeeding Among White and Black Mothers: Data from MS Maternal Child Health and Assessing the Impact of Physical Violence and Stress on Pregnancy Planning, Association of Pregnancy Intention and Preterm Birth or Low Birth Weight in MS, Making Numbers Count: Evaluating PRAMS Data Use, Barriers to Prenatal Care for Women with Pre-existing Diabetes in MS, and Hypertensive Disorder Association with Low Birth Weight or Preterm Birth. //2014//

***/2015/ MS PRAMS presented data at several conferences. Two Fact Sheets were developed and submitted for online publication. MS PRAMS has two Fact Sheets developed which are pending approval. //2015//***

MSDH Violence Prevention Program

Formerly called the Domestic Violence Program, the program uses grants from the CDC and HRSA to provide funding to 13 violence prevention shelter programs and nine Rape Crisis Center



Programs to meet the individual needs of victims entering a shelter as a result of domestic violence or sexual assault. Program staff seek to empower and enable clients by teaching life skills that promote non-violent responses which lead to a more peaceful life. Services include but are not limited to temporary safe housing, education regarding domestic violence, child care, transportation, job skills training, and group and individual counseling.

Sexual assault/rape crisis centers provide primary prevention and education activities, preventive services, and direct crisis intervention services to victims of rape and other forms of sexual assault. Primary prevention focuses on education to eliminate violence from sexual assault before it occurs. Although preventing the act from occurring is the desired outcome, prevention is not always an option. Centers spend a great deal of time providing direct service to victims of sexual assault including court advocacy, transportation, confidential counseling, family intervention, and follow-up services. Centers also provide primary prevention and education activities to the general public as well as to men and boys in an effort to increase respect for themselves, women and girls with the goal to help end or prevent the cycle of sexual and other violence against women.

#### Health Education

In addition to partnering with other providers to improve the provision of services to the MCH population, MSDH currently provides an array of health education programs on a statewide basis through district and local county health departments. Age appropriate safety education/counseling is integrated into all child health services (EPSDT clinic, health fairs, awareness events, etc). Health education is being provided to residents in the areas of poison prevention, child safety, immunization, infection control, nutrition, childhood obesity, fire safety, oral hygiene, and dental screenings. Many of these educational services are provided with the assistance of partners in communities, schools, and faith-based groups targeting youth and adolescents.

The MS Childhood Lead Poisoning Prevention Program (MSCLPPP) conducted home visits and environmental inspections for children with elevated blood lead levels  $\geq$  15  $\mu\text{g}/\text{dL}$ . MSCLPPP enhanced its program services by adopting the Healthy Housing Rating System of New England and the Healthy Home Model to include other resources on health and safety hazards found in the home (asthma, injury and fire prevention, indoor air quality, mold, mildew and pest management).

The MSCLPPP provided Healthy Housing trainings to community stakeholders on the seven principles of healthy housing (Keep it Dry, Keep it Clean, Keep it Pest Free, Keep it Safe, Keep it Contaminant-Free, Keep it Ventilated, and Keep it Maintained). The program partnered with colleges/universities, community based organizations, housing agencies, city code enforcement, day care centers and others to provide lead and healthy homes primary prevention and policy development.

***//2015/ MSDH, through its public health districts and local county health departments, provides age-appropriate health education on chronic disease, physical activity, pedestrian/bicycle safety, and tobacco cessation.***

***Health education through the Affordable Care Act (ACA) was coordinated through the Office of Health Disparity Elimination to inform the public of the application process, a glossary of medical terms and health coverage, and the Health Care Law through education sessions and dissemination of information at workshops and health fairs. In support of the Office of Health Disparity Elimination's ACA educational efforts, public health district educators will organize at least one educational session within their respective districts. //2015//***

Breast and Cervical Cancer Program (BCCP)

The BCCP provides outreach activities and educational materials to promote awareness and public education through collaborations with community groups and organizations. Prevention activities are conducted through contracts with community health centers, health departments, private providers, and hospitals to conduct screening services, diagnostic services, referrals and case management. The target populations for the program are uninsured, underinsured, and minority women. Women 50 years of age and older are the target group for mammography screening, and women 40 years and older are the target group for cervical cancer screening. The BCCP also works closely with Women's Health to ensure that all women have access to quality care and provides a Cancer Drug Program for women who are at or below 250 percent of the federal poverty level.

#### Health Services District Program Review (Improvement of Client Services)

The MSDH Office of Health Services conducts an annual District Program Review at each of the nine public health districts in order to facilitate communication between central office and field staff to improve programmatic activities at the client service level. A central office team of health care professionals consisting of a nurse, nutritionist, social worker, and other health-related disciplines meets with district administrative staff to discuss the district's involvement in each Maternal and Child Health program. Programs such as Family Planning, Maternity, EPSDT, Newborn Screening, and Early Intervention are discussed to identify opportunities for improvement of services to MSDH clients.

During the last review cycle, MCH Epidemiology was added as a major component. This component provides district and state staff the opportunity to better understand some of the causes and effects surrounding the subject of fetal-infant mortality. This component also reinforces the importance of utilizing the epidemiological process in problem solving and program planning strategies.

//2014/ The format of the Health Services District Program Review has been changed because of challenges that prevent central office staff from traveling out to the districts. Changes in funding sources and revisions to Medicaid reimbursement policies have greatly reduced and even eliminated some programs and activities that were part of the original design of the reviews. However, programmatic reviews continue within the districts by district staff with review findings submitted to central office staff with recommendations for addressing identified issues. //2014//

## **B. Agency Capacity**

### **CMP**

CMP is Mississippi's Children with Special Health Care Needs (CSHCN) Program providing care coordination and/or medical care to children with chronic or disabling conditions. Conditions covered include major orthopedic, neurological, and cardiac diagnoses, and other congenital disorders. Program services are available to state residents through 20 years of age who meet eligibility criteria. The program provides community-based specialty care through 13 clinic sites in which specialty clinic sessions are held throughout the state, including a multi-disciplinary clinic centrally located in Jackson at the Blake Clinic for Children in the Jackson Medical Mall.

CMP has a very strong link with the county health department system. Local offices and Genetics/CMP staff are utilized to provide community based CMP application sites and screening and referral services and serve as a base of operations for central office staff when clinics are held at the community level. CMP has also developed partnerships with Living Independence for Everyone (LIFE), the Cerebral Palsy Foundation, Cystic Fibrosis and Hemophilia parent support groups, American Academy of Pediatrics-MS Chapter, Division of Medicaid, the University of MS Medical Center, the Choctaw Indian Health Services, and the University of Southern MS Institute for Disability Studies (IDS) to ensure that all support services are coordinated for the patients when and where appropriate.

/2012/ CMP's partnership with the Cerebral Palsy Foundation ended in 2010 due to the closure of the MS chapter. In 2010, CMP developed a partnership with Health Help for Kids, which is a non-profit organization that assists needy families with Medicaid and CHIP applications. //2012//

/2013/ CMP developed a partnership with MS Parent Training and Information Center (MSPTI) to offer information and education in CMP's newly implemented Information and Education (I&E) Sessions. Efforts have begun to strengthen Intra-agency partnerships beginning with MSDH's Early Hearing Detection and Intervention (EHDI) program. EHDI staff recently presented at CMP's latest I&E Session to promote program activities and services. See NPM 5 for details. //2013//

The partnership with the University of Southern MS IDS has resulted in the creation of the Family 2 Family Health Information and Education Center (F2FC), a MS based family focused and family-managed entity that works to empower the families of children with special health care needs to be partners in the decision making process concerning the health of their children. F2FC is a collaboration of CMP, LIFE and the University of Southern MS IDS, and utilizes a Parent Consultant in a dual role which also includes serving as the F2FC Coordinator. At CMP clinics, the Parent Consultant provides support services to families and regularly consults with professional clinic staff concerning patient and family concerns. Through her experiences with CMP as a parent, the Parent Consultant has a unique perspective on the services CMP provides to its parents. She provides input into program and policy decision making and is relied upon to share her experience and perspective in assisting CMP in involving families in decision making at all levels. The Parent Consultant helps families to navigate the often challenging health care system and find the resources and support they need to care for their child and their family.

/2014/ The relationship with the USM IDS continues through initial stages of establishing a Family Voices -- MS Chapter in Jackson. CMP continues their commitment to the F2F Parent Consultant through this partnership in sharing part of the Parent Consultant's salary. CMP is optimistic that patients and their families will continue to benefit from the relationship with the Family/Parent Consultant via referral and the resources linked to the Family Voices chapter. //2014//

***/2015/ The relationship with the USM IDS continues through the establishment of the MS Family Voices Chapter in Jackson. USM/IDS' F2F Parent Consultant/Family Voices liaison continues to partner with CMP in her dual role of F2F/Family Voices Parent Consultant with CMP paying part of her salary. CMP is optimistic that patients and their families will continue to benefit from this relationship via referral and the resources linked to the Family Voices chapter. //2015//***

The CMP utilizes Advisory Committees to communicate with and receive feedback from health care providers and consumers. Advisory Committees include specialty and sub-specialty physicians, dentists, physical therapists, other providers, and parents of CMP patients. Through this effort, providers are advised of program efforts to increase awareness regarding program services and efforts to assist CMP patients in finding a medical home. CMP also receives input from the Parent Advisory Committee.

/2014/ CMP plans to further involve select parents on the Advisory Committee in MCH and the national AMCHP conference so that parents may gain a greater insight into the program's requirements, their role in assisting the program in meeting those requirements, and learn from neighboring states' best practices and advisory committee related activities. //2014//

***/2015/ In an effort to further reach parents and emphasize the importance of parental involvement, CMP's Director presented at the 2013 disAbility Mega Conference where she facilitated a session entitled The Significance of Parental Involvement in Promoting Positive Change. The conference is a huge annual event that is jointly sponsored by several local and state agencies and organizations that serve disabled persons. The event***

***was well attended by many parents and caretakers who expressed satisfaction with the resources and information provided at the conference. Also, as a result of past advisory committee discussions, CMP was able to offer a student position to one of CMP's former patients. This former patient who is now enrolled in college was afforded an opportunity to work 20 hours per week for several weeks over her summer break. This opportunity served a dual purpose as it allowed the student, who'd never been employed, to gain work experience, and to serve as a mentor while assisting in Blake's Transition Clinic. In the clinic, the student offered guidance and consultation to many of the younger patients attending clinic. Her presence alone served as a testament that persons with disabilities can integrate into life successfully. Many of the young people who witnessed or were assisted by the student worker in clinic were inspired and encouraged by her presence.***  
//2015//

CMP's Spanish Interpreter provides translation services to Spanish speaking families. The Spanish Interpreter also translates educational materials into Spanish to better serve families.

/2014/ CMP will work closely with the Spanish Interpreter to encourage our Spanish speaking parents to participate on the advisory committee in an effort to increase diversity. //2014//

***/2015/ Program staff will encourage Spanish speaking parents to participate on the advisory committee in an effort to increase diverse participation. Other resources to address the Latino population continue to be utilized to assist in this effort. //2015//***

/2013/ The contracted Spanish Interpreter's hours have been adjusted this fiscal period to offer our Limited English Proficient (LEP) patients and their families' greater access to translation/interpreter services. The Spanish Interpreter also offers case management assistance for those LEP patients and their families and plays a significant role in reviewing information and educational material to ensure that material is linguistically appropriate and culturally sensitive. CMP plans to work closely with the program's Spanish Interpreter and social work staff to develop a plan to improve patient and families' access to community resources. //2013//

CMP is in the process of reviewing and restructuring their internal policy and procedures starting with the revision of their interoffice policy and procedural manual. It is CMP's intent to maximize direct services and care coordination efforts to meet the greatest need. Through this process, CMP has restructured some of the services they currently cover for their specialty group of patients over the age of twenty-one, which includes sickle cell, cystic fibrosis, and hemophilia patients. The discontinued coverage will impact office visits, emergency room visits and hospitalization beginning January 1, 2012. The impact of this change has not been determined.

Anticipating the impact of this change in services, CMP provided approximately one year advance notice to all patients who may be affected. In the interim, patients have been urged to seek other sources of health care coverage through MS Medicaid, Medicare or private insurance. CMP has urged patients who may benefit from employer group health or their parents' health care plans to remain cognizant of open enrollment periods at which time they may be added. CMP's social service staff offers assistance by referring this patient population to other resources as needed.

CMP has implemented a check and balance process in handling authorization requests for payment from CMP providers. The authorization process entails a systematic approach to ensure that the greatest use of CMP funds is utilized and payment is rendered on a payer-of-last-resort basis.

/2013/ Although CMP continues to monitor the impact of this change on the groups affected, minimal to no impact has been reported. CMP attributes advance notice of the projected change and the resource information provided to this group at the time of the notice for the minimal to no post notification follow-up from the affected group. //2013//

## Adolescent Health

In order to address the increasing needs of pre-adolescents, adolescents and young adults, MSDH dedicated funds through the Maternal and Child Health Block Grant to establish the Adolescent Health Program as well as hire an Adolescent Health Coordinator in 2004. The Adolescent Health Coordinator is responsible for the strategic vision, planning and implementation of the programmatic administration and operation of the Adolescent Health program. The program serves as a resource to MS communities in assessing and addressing strengths and risks related to adolescent health status through information, consultation, technical assistance, coordination, training, assessment and evaluation.

Adolescent health information and services are provided through many existing programs within the MSDH service delivery system. Services include, but are not limited to: comprehensive health screenings and referrals, including oral health, nutritional assessment and counseling, genetic counseling, tobacco prevention, safety and injury prevention education, social services, mental health referrals, immunizations, STD/HIV education, domestic violence, rape prevention and crisis intervention, and habilitative services for adolescents with special health care needs.

The MSDH Adolescent Health Program has established collaborations with partner agencies and organizations to fulfill its mission to respond to the many issues impacting children, adolescents and young adults. Several critical initiatives include collaborating with: (a) MS Department of Education (MDE) to strengthen communications and collaboration between MDE and MSDH to support and improve HIV, STD, and unintended and teen pregnancy prevention for school-aged youth and to improve school health and public health education policies and programs; (b) MS Department of Mental Health to address an interagency system of care approach to deliver accessible and appropriate wrap-around community-based level services and treatment to children, adolescents and families with serious emotional, mental health, substance abuse disorders and/or with juvenile justice system relations; (c) MS Department of Human Services to deliver a wide range of community social services for vulnerable children, youth and their families in order to prevent and/or reduce service dependency, teen pregnancy, neglect and abuse and inappropriate institutionalization; (d) MS Alliance for School Health to improve the health of school-aged children and youth through the promotion of coordinated school health services; (e) MS Department of Employment Security to deliver basic and appropriate health services to youth in order to prevent and reduce school dropout and youth delinquency rates; (f) MS Department of Public Safety to promote safety belt use, drug and alcohol prevention, and positive youth development awareness activities and campaigns in middle and high schools; (g) MS Chapter of the American Academy of Pediatrics to eliminate the state's childhood obesity epidemic by working with policy makers, clinical improvement professionals, healthcare professionals, school administrators, educators, and parents through the National Initiative for Children's Healthcare Quality "Be Our Voice Childhood Obesity Advocacy" campaign to ensure that every child has access to high-quality care through a medical home; (h) Children's Defense Fund to champion policies and programs that lift children and adolescents out of poverty; protect youth from abuse and neglect; and ensure all children and adolescents have access to affordable comprehensive health care coverage, quality education and a moral and spiritual foundation; (i) The Salvation Army to address the psychosocial needs of children, youth and their families in order to reduce health disparities and eliminate dependence; (j) Southern Christian Services for Children and Youth, Inc., to raise awareness about the current emerging issues affecting children, youth and their families through the Lookin' To The Future Conference; (k) MS Children's Home Services (MCHS) to strengthen communications and collaboration between MCHS and MSDH to address the availability of, and accessibility to, appropriate services for children and youth with serious emotional disorders and their families, recognizing the wide array of services needed by children and youth with serious emotional disorders throughout transition; (l) Greater Jackson Chamber Partnership of Mississippi, Youth Leadership Jackson to promote positive youth leadership development, exemplary citizenship, mentorship cultivation and service learning among selected high school sophomores and juniors; and (m) Jackson State University, Department of Health, Physical Education and Recreation (HYPER) to provide interactive health educational sessions to

children and adolescents in feeder-pattern schools (elementary, middle and high schools) within Jackson Public Schools District. The following areas are included: Obesity, Nutrition and Physical Activity; Tobacco, Alcohol and Drug Use; Abstinence Education, Safety and Character Building;

/2014/ (n) The Office of Mississippi Governor Phil Bryant to implement a comprehensive campaign to reduce and prevent teen pregnancy by engaging youth, parents and local communities statewide through the Blue Ribbon Teen Pregnancy Prevention Task Force Initiative, Healthy Teens for a Better Mississippi; (o) The Mississippi Bureau of Narcotics, Mississippi Alliance for Drug Endangered Children Taskforce, a state-level, multi-agency taskforce, to ensure that all children and adolescents who are at risk of suffering physical or emotional harm as a result of illegal drug use, possession, manufacturing, cultivation or distribution are protected from drug environments and receive immediate and necessary medical care and other services when removed as well as long-term services when appropriate. //2014//

/2013/ The Office of Child and Adolescent Health plans to collaborate with MS Department of Mental Health, MS Department of Human Services, MS Department of Education, and the Attorney General's Office to create multiple one-day educational trainings focused on addressing alcohol and drug abuse, bullying prevention, underage smoking and drinking prevention techniques, cyber crimes, teen pregnancy and sexual health, and exploration of healthy choices among middle and high school students. In an effort to reduce the high school dropout rate, the trainings will be held on various community college campuses in MS. Participants attending middle and high schools will be exposed to post-secondary educational, social, and environmental settings. Based on MS Department of Mental Health data, the areas of the state with highest rates of adolescent health and mental health risk factors will be selected as potential sites. A Statewide Youth Advisory Council consisting of middle and high school students from private and public schools will be organized to assist with planning, developing, and implementing the trainings. //2013//

/2014/ The Office of Child and Adolescent Health works with Jackson Public School District to address physical and behavioral health issues in students. A national psychosocial assessment tool called TeenScreen is used annually to assess at-risk behaviors of all middle school students enrolled in the school district. The Office of Child and Adolescent Health provides Jackson Public School District with health education resource information and training for students, their parents, and teachers. Professionals address physical and mental health risk factors.

The annual Jackson State University College of Public Service, School of Social Work, MS Child Welfare Institute, is another resource that provides education and training to participants from across the state on emerging child welfare and juvenile justice practices to partner organizations and agencies working to improve services for vulnerable children, youth, and families. Continuing education credit is provided to professional groups.

The Adolescent Health Coordinator serves on numerous task forces and committees to raise awareness, educate, and plan interventions regarding critical health-risk behaviors and issues confronting children, adolescents, and young adults such as alcohol and drug abuse, bullying, violence and crime, obesity, injury and safety, teen suicide, preconception health, school dropout prevention, dating and relationships, juvenile delinquency, homelessness, peer pressure and stress, unintended and teen pregnancy and parenting among adolescents. //2014//

***/2015/ The Adolescent Health Coordinator retired November 2013 after ten years of service. The Office of Child and Adolescent Health maintains all activities and is seeking to fill the position in the coming months. //2015//***

#### Genetic Services

The Genetics Services Program provides comprehensive services statewide for a broad range of genetic related disorders. Priority is given to prevention measures to minimize the effects of these

disorders through early detection and timely medical evaluation, diagnosis and treatment. Newborn screening is mandated by law in MS. In 2003, the MSDH expanded the screening panel to include the American College of Medical Genetics (ACMG) and March of Dimes (MOD) universal panel along with other disorders/diseases recommended by the MS Genetics Advisory Committee. The program provides newborn screening for 40 disorders to identify these problems early and allow for immediate intervention to prevent irreversible physical conditions, developmental disabilities or death. Professional and patient education is provided on a yearly basis to ensure that information is readily available to the population at risk, as well as to hospitals, physicians and other health care providers.

/2013/ In April 2011 the MSDH approved the recommendation to add Severe Combined Immunodeficiency (SCID) to the Mississippi newborn screening panel effective January 1, 2012. //2013//

The CMP/Genetics team consists of a nurse, social worker and clerk in each of the nine public health districts. The team works with MSDH county and central office staff to assure adequate follow-up, care coordination and continuity of care for patients and their families.

***/2015/ In 2013 the team provided in-services for all birthing hospitals to improve specimen collection, handling and transient times to prevent delays in receipt of specimens by the screening lab. //2015//***

Clinical services are provided primarily through referrals to the University of MS Medical Center, Mississippi's only tertiary care center. Genetics satellite clinics are also routinely conducted in six public health districts in the state. These satellite clinics make genetic services more accessible for patients and families.

/2013/ To ensure that required follow-up appointments are made, CMP/Genetics Coordinators are now required to submit monthly reports indicating those children and youth to whom follow-up case management was provided for the month of reference. These activities are regularly monitored and discussed with District CMP/Genetics Coordinators and their supervisors. //2013//

#### Early Intervention (EI)

First Steps is Mississippi's early intervention system for infants and toddlers with developmental delays and disabilities and their families. The MSDH is the lead agency that assures an effective and appropriate implementation of IDEA, Part C. Other agencies such as the MS Departments of Mental Health, Education, Division of Medicaid, and Human Services collaborate with the MSDH and assist with the direct provision of early intervention services, referrals of potentially eligible infants and toddlers, and funding of the delivery of early intervention services.

A child with a developmental delay of 25 percent in any one developmental domain may be eligible for early intervention services. Infants and toddlers with conditions known to cause developmental delays are automatically eligible for services. Also, a qualified provider through informed clinical opinion can establish eligibility.

/2014/ In July 2013, after much discussion and feedback from stakeholders, First Steps revised its developmental delay criteria to 33 percent delay in any one developmental area or 25 percent delay in two or more developmental areas. This revision was based on standard deviation scores. First Steps uses one testing tool that is standardized and one tool that is norm-referenced. All First Steps services are evidenced-based. //2014//

***/2015/ MS EIP ensures through monitoring, training, and coaching that the multidisciplinary evaluation team includes the members needed to identify and address the unique needs of the child and his/her family. //2015//***

Under IDEA's child find component, the identification, location, and evaluation of infants and toddlers birth to age three is a shared responsibility of the MSDH under Part C and the MS Department of Education under Part B of the Act. The EI Program's data system, First Steps Information System (FSIS), is a tool used for monitoring and managing the program statewide and at the local level. A tickler system is being produced for service coordinators that will electronically notify them about important timelines related to services for the families.

/2014/ Revisions are currently being made to the FSIS (child database) to incorporate the new Part C Regulations. //2014//

***/2015/ Additional fields and reports in the database allow the program to capture more pertinent information on children served and as required by, the Office of Special Education Programs (OSEP)/Part C. //2015//***

/2013/ A reminder system has been developed and implemented to assist Service Coordinators and District Coordinators with notifications of important timelines related to services for children/families. //2013//

/2012/ Hand held computers have been purchased for statewide service coordinators to use in the field to expedite EI procedures and timely data entry. New and revised EI forms have been developed to meet current Individual Disability Education Act (IDEA) Part C guidelines and to make forms family friendly. //2012//

/2013/ Hand held computers are currently in use by Service Coordinators statewide and are loaded with some forms to allow the Individualized Family Service Plan (IFSP), release of information, and notices to be printed and completed in the field. IT is working with First Steps to make these forms completed in the field accessible and capable of downloading into the child registry which will reduce duplication of data input for SC staff. //2013//

/2013/ Mi-Forms and the First Steps Program collaborated on the development of an electronic form of the IFSP. An electronic copy of the IFSP has been downloaded to the SCs' notebook computers in an effort to reduce paperwork, enter timely and valid data, and to deliver necessary documents to families and providers in real time. First Steps is currently piloting this project within select Public Health Districts (PHDs). //2013//

/2014/ EI program is looking to expand this project to all EI programs in the nine PHDs. SCs will also have the capacity to print and provide copies (utilizing a portable printer) of the IFSP to parents and other participants that attend the IFSP meeting before exiting the home, childcare facility, or other natural environment settings. Other required forms for the First Steps Program will be processed for downloading to these computers for SCs use in the field. //2014//

***/2015/ The electronic Mi-Forms IFSP has been loaded statewide on the tablet for SCs to use. Other required forms will also be developed and electronically accessible on the SCs' tablets. Training has been provided to all SCs statewide. //2015//***

New FSIS user friendly data reports were created that facilitate data management by service coordinators and district coordinators. Improvements to the FSIS database make data entry easier and provide tools to assist district staff in managing their caseloads. An agency approved billing manual is provided to all EI service providers to facilitate consistent procedures for the billing of early intervention services.

In 2009, \$4.87 million in American Recovery and Reinvestment Act (ARRA) funds was received from the U.S. Department of Education. This award will assist Mississippi in the implementation of a statewide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities and their families. A Request for Proposals was completed in September of 2009 to provide statewide training.



ARRA training grants are implementing training topics such as assistive technology, personnel development, emotional and language disorders, and inclusion of children in childcare facilities with special needs. Another ARRA funded pilot project that began in late 2009 is in production in 2010. This pilot program began in Public Health District IX to address provider recruitment issues. The project is a nonprofit group which contracts with providers and facilitates processing of paperwork required for the billing of Insurance and Medicaid. In addition to training grants, ARRA funding has been used to increase the number of statewide provider contracts to serve families in the early intervention program.

/2012/ University of MS (UM) developed and conducted four training sessions to educate providers on a change in service delivery to the Primary Service Provider (PSP) model. This model has proven to create productive results and to be cost effective. University of Southern MS (USM) held training sessions across the state with childcare providers and Head Start staff to educate EI caregivers on how to implement inclusion in those settings for children. MS State University (MSU)-TK Martin Center developed four training modules on assistive technology and presented statewide to service providers and service coordinators. TK Martin Center educated providers on effective and appropriate adaptive equipment to be used in the home. Their therapy staff also demonstrated items readily accessible in the homes that could be used by parents/guardians or providers for EI children therapy needs. TK Martin Center established nine adaptive equipment lender libraries for parents and service providers to use in each health district. //2012//

/2013/ ARRA funds ended September 30, 2011. First Steps was able to enhance District and Central Office programs through stimulus funds by purchasing needed equipment, supplies, and testing tools. //2013//

The State Performance Plan and Annual Performance Reports that include baselines, targets, activities, and timelines for fourteen indicators are posted on the First Steps home page of the MSDH website HealthyMS.com.

/2012/ Also included at our website are District specific data, State Interagency Council Committee (SICC) information and EI Grant application for FY 2011. //2012//

/2013/ The current State Performance Plan, Annual Performance Report, updated Central Directory, New Part C Regulation definitions, Transition policy changes, and Head Start collaboration report have been added to the First Steps website. //2013//

/2014/ Due to a significant increase in the Hispanic and Vietnamese population in our state, First Steps has developed brochures in Spanish and Vietnamese for dissemination to these groups. This allows for both groups to understand the early intervention program and their procedural safeguards and family rights under IDEA (Individual Disability Education Act), Part C. //2014//

***/2015/ The EIP changed its criteria on which families will receive a Family Survey from the program to every family who has a child in an active status in the program with an IFSP. In FY 2013, 34% of surveys were returned to Central Office with responses. The MS Parent Training Institute (MPTI), Hispanic, and Native American interpreters will continue to be contacts provided to families for assistance in completing the survey. //2015//***

#### State Oral Health Program

The MCH Block Grant employs a full-time dental director who leads the State Oral Health Program (SOHP). Dedicated leadership is essential to assessing the oral health needs in populations, increasing awareness of oral health issues, formulating and promoting sound oral health policy, and advocating for the development of programs to prevent oral disease and promote health.

The MCH Block Grant also supports a 1.0 FTE statewide sealant program coordinator who is working with dentists at Federally Qualified Health Centers to provide school-based delivery of dental sealants to eligible children. Supplies and travel costs are reimbursed by the program. During the 2009-2010 school year, MSDH completed an open-mouth survey of third grade children in public schools. Results of the survey are detailed in both the data and narrative sections of National Performance Measure # 9.

MCH Block Grant support helps the SOHP leverage additional resources through the Office of Tobacco Control, WIC, the Office of Preventive Health, and the Bower Foundation, a philanthropic organization. For example, the SOHP supports seven dental hygienists who provide oral health screening and caries risk assessment and deliver preventive fluoride varnish to children in nine public health districts. The SOHP also provides funding to design and install new community water fluoridation systems. In FY 2009, the SOHP discontinued a weekly school fluoride rinse program for children in K through fifth grades.

The SOHP provided leadership to create the MS Oral Health Community Alliance (MOHCA) a statewide oral health coalition. MOHCA appointed an Executive Board, adopted by-laws, and prepared an action plan. MOHCA obtained tax-exemption status from the IRS as a 501(c)(3) organization in December 2009. A website for MOHCA is located at <http://www.HealthyMS.com/MOHCA>.

/2014/ With support from the DentaQuest Foundation, the Office of Oral Health worked with MOHCA to development 8 regional chapters. Regional consultants facilitated development of these groups to address priorities and support oral health activities at the community level. //2014//

/2013/ MOHCA continues to recruit members and participate in oral health promotional activities throughout the state. MOHCA is focused on building community partnerships to promote oral health by developing regional chapters and engaging key stakeholders to partner with them to find solutions that would impact the oral health of Mississippi residents. //2013//

The SOHP provides case management for children diagnosed with cleft lip and/or palate or a craniofacial syndrome that are eligible for coverage of procedures involving the oral cavity and related affected structures through the Children's Medical Program. In CY09, there were 236 payment authorizations for CMP patients with the primary diagnosis of cleft lip/palate.

/2013/ In CY11 there were 356 payment authorizations. //2013//

/2012/ Oral health services for CSHCN are limited in the state. The University of MS Medical Center has the only pediatric dentistry clinic in the state that specializes in serving CSHCN. //2012//

The MSDH also assists Head Start programs to provide preventive dental services and access to care for children enrolled in Head Start, including the application of fluoride varnish. If eligible, the MSDH bills Medicaid for the fluoride varnish application.

/2014/ The Division of Medicaid is a key partner in MS health care via reimbursement for services to patients seen in MSDH clinics. MSDH assists Medicaid in assessing pregnant women and children for Medicaid and SCHIP eligibility using MSDH staff and out-stationed eligibility workers. The MS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, Cool Kids, offers preventive and restorative dental care to eligible children. //2014//

#### CDC Coordinated School Health Initiative

The MSDH Bureau of School Health and the MS Department of Education Office of Healthy

Schools teamed to form the CDC Coordinated Approach to School Health Initiative. This initiative is funded through a five year cooperative agreement with the CDC to implement coordinated school health programs across the state and provide professional development and technical assistance in school districts with high levels of health disparities to improve the health of middle and high school students across the lifespan. The CDC coordinated approach is an eight component model that focuses on health and physical education; health, nutrition, and counseling and psychological services; a healthy school environment; health promotion for staff; and family/community involvement. Monitoring and assessment of effectiveness will focus on coordinated school health, physical activity, and nutrition programs; tobacco policy and cessation services; HIV, STD, and teen pregnancy prevention; and Youth Risk Behavior Surveillance activities.

***//2015/ The MSDH Office of Preventive Health will continue its partnership with MDE Office of Healthy Schools to conduct professional development activities and provide technical assistance to school and public health district staff regarding evidence-based strategies that promote recess, multi-component physical education policies, and sodium reduction practices. Additional professional development and technical assistance opportunities will be provided by the MSDH Office of Preventive Health, Office of Child Care Licensure and MDE to early childhood education (ECE) center staff regarding implementing physical activity strategies, regulations, and policies. //2015//***

#### Women's Health

The MSDH Office of Women's Health partners with delegate agencies, hospitals and university clinics to provide health care services to the uninsured and under-served in Mississippi. Our goal is to provide comprehensive quality health with positive outcomes and to eliminate disparities in access to health care. This wide range of activities and services are provided in house or contracted out to coordinate the delivery of comprehensive care for low income women.

*//2014/ A natural disaster planning brochure was developed for pregnant women, addressing specific concerns that may arise such as how to handle stressful events by being prepared for the situation. The pregnant woman should prepare a ready to go kit ahead of time and assure access to health care when displaced. //2014//*

***//2015/ The Office of Women's Health provides a Cancer Drug Program for indigent cancer patients in Mississippi.***

***The Director of Women's Health serves on the Community Action Committee for the Jackson Heart Study and The Community Action Network of the Delta (a Healthy Start Project). //2015//***

#### Breast and Cervical Cancer Program (BCCP)

The central aim of the BCCP is to address the breast and cervical cancer screening needs of medically underserved women in the state through outreach education and promotion of awareness. For example, the Praises in Pink program educates church members on how to coordinate a breast cancer prevention project for their respective congregation. Participants learn about risk factors and the importance of prevention and early detection. Typically, these women are uninsured, medically underserved, poor, minority women, and elderly. The age criterion for the BCCP is 40-64 and incomes cannot exceed 250 percent of the Federal Poverty Level.

In addition to breast and cervical cancer screening services provided for women 40-64, diagnostic procedures and case management services are also provided for women with abnormal findings. Women who are diagnosed with a malignancy or pre-cancerous condition of the cervix may be referred to Medicaid for treatment coverage. Staff of the BCCP provide professional and public educational programs.

/2014/ In MS, the American Cancer Society estimated that 14,990 new cases of cancer would be diagnosed in 2011, with 2,170 cases being breast cancer. Comparatively, in 2010 it was estimated that 14,330 new cases of cancer would be diagnosed and 1,970 cases would be breast cancer. According to the MSDH Vital Statistics, during 2010 there were 6,264 cancer deaths with 432 of those deaths caused by breast cancer. The BCCP served 6,625 women during Fiscal Year (FY) 11 compared to 7,491 women served in FY10, provided 4,473 mammography screening in FY11 compared to 4,094 in FY10, and 3,304 Pap tests compared to 3,146 in FY10. Carryover funding utilized in FY10 enabled the BCCP to have increased screening capacity. A woman served includes a woman receiving any CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP)-funded screen or diagnostic procedure. Diagnostic procedures include mammography, clinical breast exam or Pap test. //2014//

/2012/ From 1999 through May 2010, over 58,568 women have been screened by BCCP providers. //2012//

/2014/ Through May 2011, more than 65,046 women have been screened by BCCP providers. The BCCP collaborates with Medicaid to offer health coverage via Medicaid for treatment of women diagnosed with breast cancer, cervical cancer, and/or pre-cancerous lesions of the cervix. //2014//

#### Comprehensive Reproductive Health Program

/2014/ The Family Planning (FP) program has changed its name to "Comprehensive Reproductive Health" to better characterize the nature of the broad range of services and continuous outreach efforts to target populations while also reflecting the long-term strategic plan of the Agency. //2014//

The FP (Title X) Program promotes awareness and assures access to reproductive health benefits by encouraging individuals to make informed choices that provide opportunities for healthier lives. More than 60,237 Mississippians received comprehensive family planning services in CY 2011, and approximately 13,519 of those were age 19 years or younger.

/2014/ More than 61,003 Mississippians received comprehensive family planning services in CY 2012, and approximately 16,138 of those were age 19 years or younger. //2014//

**/2015/ More than 55,475 Mississippians received comprehensive family planning services in CY 2013, and approximately 14,112 of those were age 19 years or younger. //2015//**

The target populations are females aged 13-44 at or below 150 percent of poverty level. A fee system with a sliding scale is used where clients with an income at or below 100 percent poverty level are not charged for services. Reimbursement is sought for Medicaid eligible clients.

The FP program provides:

1. Medical and non-medical contraception methods, education, and counseling
2. Comprehensive medical examination including a thorough history, blood pressure, and items listed in the paragraph below, and provision of contraceptive method
3. Pregnancy testing and counseling
4. STD/HIV testing and counseling
5. Preconception health including enhanced documentation of services

The FP program also provides blood pressure screening, clinical breast exams, cervical cancer screening, follow-up of abnormal Pap tests and treatment, treatment for STDs, preconception care, sterilization, and infertility services. Access to other MSDH services such as WIC, immunizations, prenatal care, child health, and children's medical services is provided to family planning clients and their families as needed.

The FP Waiver Program represents a collaborative effort between the Division of Medicaid and the MSDH to increase the availability of family planning services to all women of childbearing age (13-44) with incomes at or below 185 percent of the federal poverty level who would not otherwise qualify for Medicaid. Additional collaborations include activities with other health care providers, teachers, students, patients, potential clients and networking with community and faith-based organizations that work with hard-to-reach populations in order to decrease unintended pregnancies, increase child spacing intervals, and refer for continuance of care so as to improve future birth outcomes and save Medicaid dollars.

## Maternity

MSDH Maternity Services Program aims to reduce low-birth weight, infant and maternal morbidity and mortality in MS by providing high quality, early comprehensive, risk appropriate prenatal and postpartum care utilizing an interdisciplinary team consisting of nurses, nurse practitioners, physicians, nutritionists and social workers located in county health departments in an effort to reduce low-birth weight, infant and maternal mortality and morbidity in Mississippi. During CY 2009, approximately 17 percent of the women who gave birth in Mississippi received their prenatal care in county health departments (compared to 19 percent in CY 2007). Public health nurses, nurse practitioners, physicians, nutritionists, and social workers provide this cost-effective, comprehensive primary care. WIC is a critical component of the maternity care effort.

***//2015/ During CY 2013, approximately 14 percent of the women received their prenatal care in county health departments. //2015//***

A part-time, board-certified OB/GYN continues to provide consultation statewide for the maternity, BCCP, and family planning programs.

***//2015/ All maternity clients are evaluated by the county public health team for perinatal risk at every clinic visit. Management of care is based on the level of perinatal risk reflecting national standards of care. Maternity clients and her family are encouraged to participate in developing skills and resources for future problem solving and wellness promotion. Ongoing communication is maintained to ensure continued access to needed services including referring for delivery by an obstetrician at hospitals that provide the necessary specialized care for the mother and her baby.***

## ***Pregnancy-Associated Mortality Review (PAMR)***

***See Section II.C. Needs Assessment Summary for information on the PAMR. //2015//***

## Perinatal High Risk Management/Infant Services System (PHRM/ISS)

PHRM/ISS is a comprehensive case management program targeting Women's Health Services to Medicaid eligible pregnant/postpartum women and infants up to their first birthday. The program consists of a multidisciplinary team (MS licensed RN, Nutritionist/Registered Dietitian, and Social Worker) who provide a comprehensive approach to high-risk mothers and infants for enhanced services. Targeted case management combined with the team approach establishes better treatment of the whole patient, improves the patient's access to available resources, provides for early detection of risk factors, and allows for coordinated care, all in order to reduce the incidence of low birthweight and infant and maternal mortality and morbidity. This team of professionals provides risk screening assessments, counseling, health education, home visiting, and monthly case management.

Enhanced services were also provided to health department postpartum women who were not Medicaid eligible due to their socioeconomic status. In some districts, public health nurses visit postpartum women prior to their discharge from the hospital.

***/2015/ Enhancements are being made to the PHRM/ISS program utilizing funds from a private foundation. A research based curriculum, Partners for a Healthy Baby, has been added and 120 staff trained on how to use this curriculum. An electronic data base for program analysis has been developed. An application for Healthy Families America was written and submitted April 2014. With this evidence-based case management model, preterm births, pregnant teenagers and women with EDC dates less than 14 months from a prior pregnancy will receive enhanced case management with a three year postpartum follow up. //2015//***

#### Delta Infant Mortality Elimination (DIME) Project

The DIME project's primary focus is to reduce infant mortality in the MS Delta by reducing the numbers and consequences of very low birthweight infants born to MS women. DIME targets gaps in women's and infants' health services in the 18 counties of the Delta Health Alliance initiative. DIME is a multidimensional, multicollaborative effort including the MSDH, the University of MS School of Medicine, and Federally Qualified Health Centers.

The DIME project proposes to accomplish its goal of decreasing infant mortality in the MS Delta by: 1) Filling gaps in healthcare services for women and infants; 2) Increasing efficiency and utilization of available healthcare services for women and infants; and 3) Enhancing knowledge and skills of healthcare consumers and providers in the Delta.

The DIME project strategically assembles partners to increase the number of providers in the Delta, enhance case management and follow up services, initiate post-partum home visitation activities and increase access to women's healthcare and chronic disease management. Examples include family planning services, mental health services, social services, general medical and dental services, transportation assistance, and drug coverage. An additional DIME component is coordinated infant death review conferences among health department and local providers to gain insight on opportunities to improve outcomes for infants and families of the MS Delta. Outreach and educational services will be provided at individual, community, and professional education levels.

#### Metropolitan Infant Mortality Elimination (MIME) Project

The MIME project is the sister project of the DIME program. The MIME project is being piloted in the Jackson Metropolitan Area utilizing the same interpregnancy care project components used in the DIME project.

The DIME and MIME projects provide rural and urban perspectives of interpregnancy care implementation strategies in MS. After extensive research design and evaluation planning, DIME and MIME were finalized and multi-agency institutional review board approval was obtained. Enrollment of participants was initiated in mid-February 2009 and the first participant was enrolled on only the third day of recruitment.

*/2012/ Funding for DIME/MIME is ending; see SPM 1 & 9 narrative for details. //2012//*

*/2014/ The DIME project closed out the last client February 2013. The MIME project will close out the last client June 2013. //2014//*

***/2015/ The MIME project closed out the last client June 2013. See SPM 9 for data analysis details. //2015//***

### C. Organizational Structure

State agency functions are divided between the Governor and the Legislature according to agency structure. The Mississippi Development Authority (MDA), the Division of Medicaid, and the Department of Human Services (DHS) are executive branch agencies, while the Mississippi State Department of Health (MSDH) is independent. Independent agencies are governed by boards whose members are appointed by the Governor. The Governor maintains indirect influence through these appointments, but independent agencies must deal more directly with the legislature in negotiating budgets and significant policy changes. With the mix of executive and independent agencies, state agency heads do not function together as a cabinet, a situation that results in a number of horizontal power bases within the state government structure.

MSDH is the state agency responsible for administering the Title V MCH Block Grant. These funds are allocated in the central office to the Offices of Women's Health and Child and Adolescent Health. CMP is located in the Office of Child and Adolescent Health. All are located organizationally within Health Services (HS). Women's Health and Child and Adolescent Health provide services for the three major populations targeted by the MCH Block Grant: women and infants, children and adolescents, and children with special health care needs.

The MSDH is organized into nine public health districts, each with its own district health officer, and more than 100 public health and specialty clinics that service all 82 counties. The District Chief Nurse oversees all public health nursing activities in the district and supervises the MCH/Family Planning Coordinator. Services include prenatal and postnatal care, well child and sick child care, as well as restorative services for CSHCN. This network allows the MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

The Office of Health Services directly supports the agency's mission to promote and protect the health of Mississippians through a variety of programs designed to prevent disease, maintain health, and promote wellness for Mississippians of all ages. The Office of Health Services has two primary areas of focus: Health Maintenance and Health Promotion. Health Maintenance strives to improve healthcare services for women and infants, increase efficiency and utilization of available services, and enhance knowledge and skills of both consumers and providers of healthcare services. Health Promotion encourages achievement of optimal health and physical well-being while seeking to minimize risks for chronic disease and injuries. Health Promotion programs benefit Mississippians who want to improve and secure their health. Together, the two areas provide a comprehensive approach to improving health outcomes, which in turn leads to reduced morbidity and mortality among Mississippians.

An official and dated organization chart is provided as an attachment to this section.

***An attachment is included in this section. IIIC - Organizational Structure***

## **D. Other MCH Capacity**

In December 2009, State Health Officer Dr. F. E. Thompson, Jr., passed away after a lengthy illness. Dr. Mary Currier, who was serving as State Epidemiologist, was selected by the State Board of Health to serve as Mississippi's new State Health Officer. Dr. Currier served as Mississippi's State Epidemiologist from 1993 to 2004 and 2007-2010. Dr. Paul Byers, a physician in the Epidemiology office, was named Acting State Epidemiologist in February 2010.

Within Health Services there are three offices that serve the maternal and child health population. They are listed below with the Central Office and District FTE of each:

1) Office of WIC :

a) 42 central office staff including administrative, information technology, shipping & receiving, and accounting personnel;

b) 646 district/county staff including administrative, clinical, and food center personnel.

2) Office of Women's Health -- 26 central office and field staff.

- 3) Office of Child/Adolescent Health, including Children with Special Health Care Needs:
- a) Genetics has 15 central office and 25 field staff;
  - b) Child Health has 4 central office staff;
  - c) CMP has 18 central office, 2 field staff, and 3 independent contract employees: a Dental Consultant, a Spanish Interpreter/Translator and a Speech Therapist. There is also an independent contract Physical Therapist position that is vacant and not included in this number. There are 3 contract employees that include the Family 2 Family Parent Consultant and 2 contract Nutritionists whose contracts are currently being considered;
  - d) Early Intervention has 12 central office and 65 field staff;
  - e) Total Child/Adolescent staff = 63 central office and 100 field staff.

#### Biographical Sketches of Key MCH Personnel

Daniel R. Bender, MHS, currently serves as the Director of the Office of Health Services. Mr. Bender was the Director of the Genetics Program from 1983 to 2000, where he worked toward the passage of laws mandating newborn screening for PKU, T4 (TSH), Hgb and Galactosemia. Mr. Bender started nine satellite genetic clinics in the state and started the first genetics database in Mississippi (MS). He also developed the MS Birth Defects registry. Mr. Bender's medical experiences include registered Emergency Medical Technician for Baldwin Ambulance and Director of Rankin County Emergency Medical Services. His education includes a Bachelor of Science Degree in Special Education and Master's Degree in Health Science.

/2013/ Mr. Bender retired on May 31, 2012, and was succeeded by Ms. Kathy G. Burk. Ms. Burk was most recently the Director of the MSDH Office of WIC and came to MSDH in 1994 as the District Social Work Supervisor for District V. In 1997 she was promoted to the State Social Services Director and in 1999 received another promotion as the Deputy Field Services Director. She has over 22 years of service and management experience in state government, having worked 13 years with the MS Department of Human Services. She earned a Bachelor of Social Work degree from MS University for Women and a Master of Social Work degree from the University of Southern MS. She also received the Certificate of Achievement from the Tulane School of Public Health and Tropical Medicine for completion of the South Central Public Health Leadership Institute and is a graduate of the Certified Public Manager's Program through the MS State Personnel Board. //2013//

Wesley F. Prater, MD, is a board-certified obstetrician/gynecologist whose career spans over 30 years. The first 25 years were spent exclusively in the private sector where his passion was, and continues to be, Maternal and Infant care. Dr. Prater served on Mississippi's initial Infant Mortality Task Force. The last five years in the private sector was combined with working in a community health center as the Director of Women's Health and as Medical Director for one year. At Madison County Medical Center, Canton, Mississippi, Dr. Prater has served as Director of the Obstetrics & Gynecology and Surgery Departments, Chief of Staff and Board Chairman. The professional organizations that he has devoted the majority of his time to include the Gynecic Society, Mississippi Medical and Surgical Association, and the National Medical Association. Dr. Prater has held a leadership role in most of his professional organizations.

Rosalyn Walker, M.D., is a board certified pediatrician who provides consultation to MSDH. She has twenty years of experience in general pediatrics and pediatric pulmonology, especially in the care of children with chronic illness and special health care needs. Dr. Walker joined the department in September 2006 and is a link between community health care providers, tertiary care providers and MSDH. Special interests include newborn screening and care of children with special health care needs.

Louisa Young Denson LSW, MPPA, CPM, is currently the Director of the MSDH Office of Women's Health. Previously, she served as the Director of Disparity Elimination, Director of Minority Affairs, Office Systems Advisor for all clerical staff with the agency, Immunization Representative for 11 counties in District V, Hinds County Office Manager (which consisted of 11



clinics), Director of the Mary C. Jones Clinic, Public Health Advisor for the Sexually Transmitted Disease Program and a clerk in Vital Records and Statistics. Ms. Denson has a Master's in Public Policy and Administration, Bachelor's degree in Social Work, and is a licensed social worker. She has also completed the Certified Public Managers Program with the State Personnel Board.

Geneva Cannon RN, MHS, is Director of the Office of Child and Adolescent Health. Ms. Cannon has over twenty years of experience as a pediatric nurse in critical care, public health, and administration. She was employed with the MSDH in the late 1980's and early 1990's as a nurse with the Genetics Program and later as a nurse consultant with the Office of Child and Adolescent Health. Her career also includes working as Director of Licensure and Practice with the MS Board of Nursing. Prior to her current position, she worked as the Program Coordinator in the planning and implementation of the separate insurance plan for the state's Children's Health Insurance Program.

/2014/ Ms. Cannon retired on June 30, 2013. //2014//

Lawrence H. Clark is the Director of the Children's Medical Program, Mississippi's Title V Children with Special Health Care Needs program. He has over 25 years of supervisory and management experience. He has worked with Allstate Insurance Company in Jackson, MS, and in Chicago, IL. He also has 13 years of managerial experience with the MS Development Authority. Before joining the MSDH staff, he was employed with the MS Department of Education, Office of Special Education, where he managed several statewide initiatives.

/2012/ Mr. Clark retired during the past year. Patricia Bailey was appointed the Director of the Children's Medical Program after serving as both the Social Worker Consultant and Acting Director. She is a Licensed Master Social Worker with over 13 years experience in serving diverse populations. Ms. Bailey earned both her Bachelor and Master Degrees in Social Work from Jackson State University. She was also employed as the Social Worker Consultant for the state's Title X Family Planning Program. Before joining the MSDH staff, Ms. Bailey was employed with Baptist Health Systems in Jackson. //2012//

Juanita Graham, DNP, MSN, RN is the Grants and Special Projects Coordinator. Dr. Graham participates in a variety of activities including grant writing, continuing education for nurses, logic modeling, program development, evaluation, and research. She holds both Bachelor's, Master's, and Doctoral degrees in the Nursing Sciences from the University of MS. She teaches and develops online courses for several nursing and healthcare administration programs and holds a number of adjunct faculty appointments Georgetown University and The DeVry Institute. Juanita holds a number of executive positions and appointments including Director of the Mississippi Council on Nursing Research within the Mississippi Nurses Association Executive Board, Executive Board Member for the Association of State and Territorial Directors of Nursing, National Delegate to the American Nurses Association, and International Delegate to the Sigma Theta Tau International Nursing Honor Society. She has given several state, national, and international presentations on a variety of topics ranging from logic modeling to infant mortality.

Virginia L. Green, MD, began working with Children's Medical Program (CMP), Mississippi's Title V CSHCN program, in 1986, as Pediatric Consultant. Other pediatric experience includes: private practice in Montgomery, AL, 1980-1983; pediatrician for District V, MSDH, 1983-1986; pediatrician and Assistant Professor of Pediatrics, Department of Pediatric Gastroenterology, University of MS Medical Center (UMC), 1991 -1993. She also served as a review pediatrician for MS Disability Determination Services (DDS), reviewing childhood cases for eligibility for Supplemental Security Income (SSI) and Medicaid, 1991 -1993. In 1994, she returned to CMP as the Program's Medical Director.

***/2015/ Leigh R. Campbell, MD, was appointed March 1, 2014, as the Child & Adolescent Health Medical Director, which includes responsibilities formerly performed by Drs. Rosalyn Walker and Virginia Green. Responsibilities include providing pediatric and***

***adolescent consultations, and consulting and working in the Children's Medical Program (CMP) clinics. Dr. Campbell served as Assistant Professor of Pediatrics, Division of Neonatology at the University of Mississippi Medical Center (UMMC) for the past two and a half years where she also received her medical degree. She completed a fellowship in Neonatology at the University of Alabama at Birmingham and Residency in Pediatrics at UMMC. She holds Board Certifications in both Neonatal-Perinatal and Pediatric Medicine. Additionally, Dr. Campbell has co-authored numerous medical articles on pediatric research. //2015//***

Lei Zhang, PhD, MBA, is the director of the Office of Health Data & Research and is the Principal Investigator of the MS Asthma Program, the MS Pregnancy Risk Assessment and Monitoring System (PRAMS), and the State Systems Development Initiative (SSDI). He provides guidance on data collection and analysis within Health Services. Dr. Zhang holds adjunct academic appointments at the University of Mississippi Medical Center and Jackson State University. He received an MBA from the University of Louisiana at Monroe and a PhD in Preventive Medicine from the University of Mississippi. Dr. Zhang is a Certified Public Manager and has published 39 peer-reviewed articles related to infant mortality, childhood obesity, asthma, and school health.

Dr. Nicholas Mosca is State Dental Director for MSDH and Clinical Professor of Pediatric and Public Health Dentistry at the University of MS Medical Center School of Dentistry. A 1987 graduate of Loyola University School of Dentistry, Dr. Mosca completed a two-year General Practice Residency at Charity Hospital Center in New Orleans. From 1989 to 1999, he served as director of the Hospital Dental Clinic at the University of MS Medical Center and later served as clinic coordinator for the Jackson Medical Mall Outpatient Dental Clinic. Dr. Mosca is currently enrolled as a doctoral student at the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill.

/2013/ Dr. Mosca left the position of State Dental Director during CY11 and Dr. Dionne Richardson joined the MS State Department of Health in December 2011 as the State Dental Director. Prior to joining MSDH she served as State Dental Director with the LA Department of Health and Hospital's Oral Health Program for five years, and was duly appointed as Assistant Professor at the LSU Health Sciences Center School of Dentistry. Dr. Richardson was also a member of the faculty at Eastman Dental Center in Rochester, NY, and served as an adjunct faculty member in the Community and Preventive Medicine Department of the University of Rochester Medical Center where she taught graduate students and first year medical students. In 1994, she received her Doctor of Dental Surgery degree from Meharry Medical College School of Dentistry in Nashville, TN, and in 1998 she received a Master of Public Health degree from the University of Rochester in Rochester, NY. She completed residencies in Advanced Education in General Dentistry and Public Health at the Eastman Dental Center. She was also a health services research fellow with the Agency for Healthcare Research and Quality and served as a data abstractor for CDC's Community and Preventive Services Task Force to develop the oral health section of the Guide to Community and Preventive Services. //2013//

Donna Speed, MS, RD, LD serves as the Nutrition Services Director and coordinator for the Fruits & Veggies-More Matters program for the state. She has 30 years of experience, much of it working with the public and community in the area of disease prevention and wellness. Donna works with the WIC program and the Department of Education to promote a healthier lifestyle for women, infants, and children. She serves as the education/nutrition chairman for MS Chronic Illness Coalition and the MS Comprehensive Cancer Control Program, among others, and serves on the orientation, annual meeting and MCH committees of the Association of State & Territorial Public Health Nutrition Directors. Donna is also national chair-elect of the Fruit & Veggies-More Matters Council.

Danielle Seale, LCSW, Public Health Social Services Director, provides a professional social services perspective and consultation to the director of Health Services and other MSDH programs regarding policy development, standard setting, and the establishment of service

priorities in addition to oversight, consultation and professional consultation to nine social services regional directors and state level social work consultants. She is credentialed at the Licensed, Certified Social Work level, received a bachelor degree from the University of Tennessee in psychology with a minor in child and family studies, and a Master of Social Work degree from the University of Southern Mississippi. Danielle is also the 2012-2013 President of the Association of State and Territorial Public Health Social Workers and serves on the Mississippi Board of Examiners for Social Workers and Marriage and Family Therapists Continuing Education Committee.

John Justice, MHSA, was appointed in February 2009 to serve as the MCH Block Grant Coordinator for MSDH. John began his employment with MSDH in August 1992 as a Public Health Environmentalist in Hinds County (Jackson) MS. In 2004, he joined the MSDH Office of Oral Health as the Fluoridation Administrator where he oversaw the MS Community Water Fluoridation Program. In 2005 and 2006, John received national awards from The Centers for Disease Control & Prevention (CDC), the Association of State & Territorial Dental Directors, and the American Dental Association for his work to increase the proportion of population in MS that receives the benefits of fluoridated water. In 2006, he served on a CDC Expert Panel on Engineering and Administrative Recommendations for Water Fluoridation and has given over 100 presentations on water fluoridation and oral health. John is a graduate of Tulane University School of Public Health and Tropical Medicine's South Central Public Health Leadership Institute having received his certificate in 2006.

Mary M. Wesley, MPH, serves as an MCH Epidemiologist in the Office of Health Data & Research and assists with MCH Block Grant data management, implementation of the State Systems Development Initiative (SSDI) grant, and statistical support for MCH programs. Other responsibilities include data analysis for the MS PRAMS programs. Ms. Wesley's research interests include maternal and child health, adolescent obesity, adolescent mental health, and infectious diseases and has had numerous articles published in peer reviewed journals. Ms. Wesley earned her Bachelor of Science degree in Biology from Prairie View A & M University and her Master of Public Health degree with an emphasis in Epidemiology from the University of Alabama at Birmingham.

Connie Bish, PhD, MPH, is the State MCH Epidemiologist assigned from Centers for Disease Control and Prevention (CDC) to MSDH. Dr. Bish has a Ph.D. in Biological and Biomedical Science specializing in Nutrition and Health Science from the Graduate School of Arts and Sciences, Emory University, in Atlanta, GA. Dr. Bish also has a Master of Public Health degree in Epidemiology from the Rollins School of Public Health, Emory University. Currently, she is an epidemiologist with the Maternal and Child Health Epidemiology Team in the Applied Sciences Branch within the Division of Reproductive Health (DRH) at the CDC and is assigned to MSDH as the State MCH Epidemiologist. Her public health career began in 1992 while employed by the United States Department of Agriculture as a poultry scientist in the Northeastern US. She later completed the MPH and PhD degrees in 2002 and 2006, respectively. Her research interests include the influence of body mass index, nutrition and metabolism on reproductive outcomes, preterm birth, fetal and infant morbidity and mortality, health disparities, SIDS and other sudden, unexpected infant deaths, preconception health, and epidemiologic methods. Dr. Bish provides expertise as a consultant on all maternal and child health policy and program initiatives and is helping to implement the life course perspective within MSDH.

//2014/ Dr. Bish left her position as CDC-assignee for the MSDH in December 2012. //2014//

//2014/ Charlene Collier, MD, MPH, has worked as a perinatal health consultant for the MSDH since March 2012, working on the Collaborative Improvement and Innovation Network to Reduce Infant Mortality. In July 2013, she will be an Assistant Professor of Obstetrics and Gynecology at the University of Mississippi Medical Center and continue to dedicate forty percent of her time to public health work and research with the MSDH directing efforts to improve birth outcomes. Dr. Collier earned her undergraduate and medical degrees from Brown. She then received an MPH

from Harvard's School of Public Health and completed residency training in obstetrics and gynecology at Yale. Dr. Collier's research focus is on disparities in preterm birth, particularly understanding the impact of maternal stress, support networks, and education on preterm birth. She is also interested in outcomes and cost-effectiveness research in robotic surgery in gynecology. //2014//

#### Cultural Competency

In an effort to develop cultural competency within the agency to better meet the needs of and improve service delivery to Mississippi's immigrant population, workshops were conducted in the last year by the MSDH Office of Health Disparity Elimination (OHDE) during which approximately 2,200 staff were provided training in cultural competency by experts from the Morehouse School of Medicine. The MSDH OHDE also employs an Outreach Coordinator to provide guidance on multicultural perspectives including those of the Middle Eastern and Hispanic communities and to assist with the certification of MSDH translators.

***/2015/ In 2014 through an Office of Minority Health Grant, The Office of Health Disparity Elimination entered into a contract with the National Center for Cultural Competence to provide a series of webinars among MSDH staff (required of all MSDH staff agency wide) and federally qualified community health centers staff that focus on three areas: Cultural Competence, Linguistic Competence and the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). These trainings will facilitate an improved cross-cultural communication between Low English Proficiency (LEP) patients and MSDH staff by providing interpretation and translation assistance to the MSDH districts, field, departments and programs. It will also encompass outreach work in the community, assist district and county level staff to understand and respond effectively to the cultural and linguistic needs of the agency patients, assist with interpretation services at the District level, provide assistance to the different MSDH departments and programs in the translation of agency materials from English to Spanish, the revision of previously translated forms, the training of interpreters, and serve outreach workers within the various communities. The MSDH Office of Health Disparity Elimination also employs Outreach Coordinators to provide guidance on multicultural perspectives including those of the Middle Eastern and Hispanic communities and to assist with the certification of MSDH translators. //2015//***

#### E. State Agency Coordination

The CDC and HRSA provide funding for most services implemented through Health Services. Less than one percent of total funding for Health Services is provided by the State of Mississippi (MS). Therefore, many MCH programs funded through Title V work in cooperation with national resources such as CDC and other HRSA Maternal and Child Health Bureau programs. Program staff are constantly in touch with project directors at the national level to ensure that needed services are provided to the MCH population. Additionally, organizational relationships exist between MSDH and other human service agencies that work to enhance the capacity of the Title V program. Examples are given below.

#### Alcohol and Drug Prevention Programs

The Born Free project, which MSDH originated, networks available community resources for the provision of services to substance-involved pregnant women and their infants. Other agencies involved in the Born Free network include: (a) the University of MS Medical Center (UMMC); (b) Marian Hill Chemical Dependency Treatment Center; (c) New Life for Women (housing); (d) Catholic Charities (provides direct primary treatment services and transitional program services); (e) community health centers (CHCs); (f) Jackson Recovery Center; (g) state mental health centers and state hospital; (h) parole officers and the court system; and, (i) sexual assault and domestic violence shelters and other treatment centers. Born Free is now administered by the

local chapter of Catholic Charities whose mission is to provide services to people in need, advocate for justice, and to call others to do the same.

The MSDH Adolescent Health Coordinator actively serves on the MS Department of Mental Health (MDMH) Alcohol and Drug Abuse Advisory Council in order to advise and support prevention and treatment programs aimed at reducing alcohol and drug abuse among adolescents and young adults. The Council promotes and assists the Bureau of Alcohol and Drug Abuse with developing effective youth prevention programs, providing input on the development of the annual State Plan for Alcohol and Drug Abuse Services, participating in the MDMH's peer review process, and promoting the further development of alcohol and drug treatment programs at the community level.

//2014/ The MSDH Adolescent Health Coordinator collaborated with the MS Bureau of Narcotics to establish the newly formed Mississippi Alliance for Drug Endangered Children Taskforce, a state-level, multi-agency taskforce working together to ensure that all children and adolescents who are at risk of suffering physical or emotional harm as a result of illegal drug use, possession, manufacturing, cultivation or distribution are protected. The overarching goal of the taskforce is to ensure that all children and adolescents removed from drug environments will not only receive necessary immediate medical care and other services, but will also receive long-term services when appropriate. The pilot programs will include: Hinds, Madison, and Rankin Counties. //2014//

#### Children's Medical Program (CMP)

CMP, the state CSHCN program, maintains an Advisory Council whose members include medical and other service providers and parents of CSHCN. Medical service providers of the Advisory Council include private physicians, a dentist, orthotics/prosthetics provider, and staff physicians of UMMC, the only state funded medical teaching and tertiary care facility. A representative from the MSDH also serves on the MS Council on Developmental Disabilities, an appointed group of people designed to support individuals with developmental disabilities, their families and the community in which they live and develop strategies to support systemic change. CMP partners with the MS Disability Determination Service providing for the exchange of respective program eligibility criteria in cross referral of CSHCN for services.

CMP maintains a Parent Advisory Committee composed of parents of CSHCN covered by the program and who graduated from the program. Parents provide input regarding the services that their children receive from the CSHCN program. Many of these parents represent organizations that share in providing services to the special needs population CMP serves. Examples include Jackson State University, Methodist Rehab Center, Magnolia Speech School, and the University of MS Institute for Disability Studies.

//2013/ CMP now has an active Statewide Parent/Professional Advisory Committee which includes parents and other key stakeholders. //2013//

//2014/ CMP recently enhanced its relationship with Mississippi's only tertiary health center, University of Mississippi's Medical Center. In an effort to move the program into the electronic medical record age and further enhance patient care coordination, CMP is in their final stages of joining UMMC in sharing their EPIC Care Link electronic medical record system. Training on this site is scheduled for late May for most of CMP's Blake Clinic clinical staff. Access rights have been granted in three tiers: the Provider, which is the highest tier allowing all access, the Nursing tier, and the Administrative tier that will allow limited Clerk scheduling access. Currently, the Medical Director, Program Director, limited Blake Clinic clerical staff, nurse staff, the program social worker and contract Interpreter all have user rights on the system within their respective scope of expertise. This site is designed to replace telephone calls to fax and receive UMMC's patient records. It will allow CMP's clinical staff to place and schedule orders to UMMC, place referrals to UMMC providers, view and record Social Work case notes and receive InBasket messages with UMMC providers. //2014//

***/2015/ CMP's work with Mississippi's only tertiary health center, the University of Mississippi Medical Center (UMMC), to share their EPIC Care Link electronic medical record system has been finalized. CMP staff have been trained in their respective roles in accessing this system. Thus far, it has worked well in enhancing CMP's delivery of the gap filling service of care coordination. //2015//***

#### Community Health Centers/MS Primary Health Care Association

A primary care cooperative agreement with the MSDH Bureau of Primary Health Care has been administered by the MSDH since 1985. The cooperative agreement provides a mechanism for joint perinatal planning and provider education between the state MCH program and the CHCs. Perinatal providers are placed in communities of greatest need through a joint decision-making process of the MS Primary Health Care Association (MPHCA) and the MSDH Primary Care Development Program, making access to care available to many pregnant women and their infants. CHCs also participate in the MSDH school-based dental sealant program to increase utilization of sealants among eight year old children.

MSDH also partners with CHCs on the Empowering Communities for a Healthy MS Conference each May. Information is available at:  
<http://www.dreamincevents.org/healthymsconference2/DMH.html>.

#### Family Planning

*/2014/ The Family Planning (FP) program has changed its name to "Comprehensive Reproductive Health" to better characterize the nature of the broad range of services and continuous outreach efforts to target populations while also reflecting the long-term strategic plan of the Agency. //2014//*

***/2015/ The MSDH will continue the new and innovative informational booths at the State Baptist Convention and other venues along with other services statewide. See NPM 8 for this year for other updates. //2015//***

The MSDH Family Planning Program maintains contracts with community health centers and with universities and/or colleges for the provision of contraceptive supplies and educational materials. Family planning staff at the central office, district, and local health department levels provide continuous informal collaboration and consultation to persons from the community including other health care providers, teachers, students, patients, potential clients, and organizations. This includes providing and assisting with presentations, health fairs, and training. Family planning staff also participate with different agencies, task forces, and coalitions in providing supportive services to various communities such as letters of support, assistance with grant writing, and service on various coalitions and community councils.

*/2014/ The MSDH Family Planning Program has established contracts with 33 Delegate Agency Providers which include: 30 CHCs located in Public Health Districts I, II, III, IV, V, and VIII; two (2) Job Corps Centers in Public Health Districts I and V; and one (1) University Student Health Center in Public Health District V. Several of these entities have access to or are located in school based clinic settings (Aaron E. Henry Community Health Center in District I, Jackson Medical Mall Foundation Convenient Care Clinic, MS Job Corp Center in District V, Finch Henry Job Corp Center) and service a larger population of teens. All provide contraceptive supplies, education, and counseling (supplies are provided by MSDH Family Planning Program funded through Title X). //2014//*

The Jackson Medical Mall Pregnancy Prevention Project addresses teenage pregnancy prevention in two Jackson area schools, Lanier and Forrest Hill High Schools, through education, counseling and providing clinical services to address their family planning and reproductive health

needs. Their efforts should assure timely intervention and ongoing support to students determined to be at risk, thereby reducing sexual behavior and subsequent pregnancies in many. /2012/ Discontinued //2012//

The G.A. Carmichael Family Health Center (GACFHC) Community Health Center Pregnancy Prevention Program addresses teenage pregnancy prevention through abstinence education in school-based clinics in two of the three counties served by GACFHC as well as teaching abstinence during certain school periods. Teens participate in Teen Summit held during the month of May where abstinence, pregnancy and disease prevention are discussed. /2012/ Discontinued //2012//

#### First Steps Early Intervention System (FSEIS)

The FSEIS is structurally located within the Office of Child and Adolescent Health, and has established an Interagency Coordinating Council to bring together the state departments of Mental Health, Education, and Human Services; the Division of Medicaid; universities, providers of services, and others to develop a comprehensive system of family-centered, community based, culturally-competent services. Local interagency councils and stakeholder groups support the planning, development and implementation of the system at the community level.

/2012/ Future plans are being made to provide a child development training statewide for service providers, service coordinators, and health department nursing staff. This training is to focus on typical child development and to assist staff with understanding how to determine appropriate delays for correct EI referral. The training should provide better knowledge of a child's development for provider and service coordinator staff when evaluating, serving, and implementing appropriate IFSP outcomes, activities, and strategies. //2012//

/2013/ The training was held statewide in 2011. A new training on Early Childhood Outcomes occurred in April 2012 to assist EI staff and providers to develop better child outcomes on the IFSPs. Improved child outcomes will enhance the activities and results for children and their families. //2013//

/2014/ In 2012, training on the "Primary Service Provider (PSP) Model" was provided for EI staff in Districts VIII and IX. Additional trainings on the PSP Model are being developed and will be provided for EI staff statewide. This model provides an effective method of service delivery for families of children receiving EI services. //2014//

***/2015/ Last year, statewide training occurred in four locations to educate EIP staff on the screening tool, Ages & Stages. This year, the Early Childhood Technical Assistance (ECTA) Center will provide a series of webinars to EIP staff on how to develop appropriate IFSP goals/activities related to the Present Level of Development (PLOD) scores. //2015//***

#### Healthy Linkages

UMMC, federally qualified community health centers, and MSDH have collaborated to form the MS Healthy Linkages Project, a formal patient referral process for MSDH county clinics, the state's 21 federally qualified community health centers, and the university in order to improve outcomes for the maternal and child health population in MS.

#### /2014/ U.S. Housing and Urban Development (HUD)

In October 2012, HUD began collaborating with MSDH, Delta HealthPartners Healthy Start Initiative, and MS Department of Human Services Healthy Homes Mississippi with the goal of bringing health and social services to the residents in the Housing and Urban Development communities. Three pilot sites have been identified: Vicksburg Housing Authority, Canton Housing Authority, and the South Delta Regional Housing Authority. Vicksburg and Canton are

multi-family units and South Delta covers six counties through Section 8 Housing Vouchers. Each site has been individualized to meet the unique needs of each community. //2014//

***/2015/ To address individual needs, health education was provided to each House Authority program during 2014. Due to changes in staffing, this collaborative effort focus has been dissolved. //2015//***

Department of Human Services (DHS)

DHS coordinates services for children/youth in foster care that include case management, child care for the developmentally disabled, services for the chronic mentally ill, abstinence education, and treatment for alcohol and chemically dependent adolescents.

DHS Office of Children and Youth uses funds for day care, while the Division of Aging and Adult Services uses Social Services Block Grant (SSBG) funds for home health aides, ombudsmen services, transportation for elderly, case management for adults, adult day care, home delivered meals for adults, and respite care. The MSDH no longer receives SSBG funds from the DHS to assist in its efforts to provide needed contraceptive services to teens; however, a representative of the MSDH is a member of the DHS Out-of-Wedlock Task Force.

DHS administers the federal Child Care Development Block Grant (CCDBG) which has two basic component areas. The provision of actual child care services comprises 75 percent of the budget. The Quality Child Care Development portion of the budget provides funds for training of child care providers, improvements to day care centers, and media centers. Some CCDBG funds are provided to the MSDH for child care facilities licensure.

/2012/ DHS is the lead agency for the implementation of HRSA's Maternal, Infant, and Early Childhood Home Visiting Program. The Healthy Homes MS program will provide family support workers who will assist high-risk families with physical and mental health issues, financial planning, parenting information, community supports and services, and building healthy social support networks. The program will begin late summer of 2011 in Claiborne, Copiah, and Jefferson counties. //2012//

/2014/ The Healthy Homes MS program implemented the Healthy Family America (HFA) home visiting program utilizing the Partners for a Healthy Baby (PHB) curriculum. The counties selected for the home visiting program are clustered into two groups: Claiborne, Copiah, Jefferson and Wilkinson counties in southwest Mississippi and Coahoma, Tallahatchie and Tunica counties in northwest Mississippi. //2014//

March of Dimes (MOD)

***/2015/ MSDH partners with MOD to increase awareness of prematurity and folic acid to reduce birth defects. MSDH collaborates with MOD's "Healthy Babies are Worth the Wait" (HBWW) initiative to prevent preventable preterm birth, focusing on reducing elective deliveries before 39 weeks gestation. Thirty-six of Mississippi's forty-five delivery hospitals (80%) have committed to reduce unnecessary early elective deliveries (before 39 weeks) to 5% or less of all births. Six hospitals have already met this goal. //2015//***

/2014/ MSDH and the MOD are working with the MS Chapters of the American Association of Pediatrics, the American Congress of Obstetricians and Gynecologists, the Mississippi Hospital Association, the Division of Medicaid, and the University of MS Medical Center to increase healthy births in Mississippi.

MSDH leaders are pledging support to give more babies a healthy start in life by accepting a challenge to lower the state's pre-term birth rate eight percent by 2014. The challenge was issued by Association of State and Territorial Health Officers (ASTHO) President Dr. David Lakey, and is



endorsed by the MOD. The goal is to lower Mississippi's pre-term birth rate to 16.6 percent.  
//2014//

The March of Dimes launched a campaign to raise awareness of the growing problem of prematurity and to decrease the rate of preterm births. Premature infants are more likely to be born with low birth weight and suffer mild to severe disabilities and/or death. Prematurity is the leading cause of infant death before the first month of life. Fifty to seventy percent of neural tube defects could be prevented if women took 0.4 mg of folic acid daily before and during pregnancy.

/2014/ The following events have occurred to provide awareness of infant mortality in Mississippi: March for Babies, Jackson's Signature Chef Auction, the 8th Annual MOD Spotlight on Success event held in Biloxi in October 2012, and the MOD Johnny Evans Telethon held in Greenville, MS, in February 2013. //2014//

/2013/ MSDH is working with March of Dimes and other partners to decrease infant mortality from 9.6 deaths/1000 live births in 2010 to 8.8 deaths/1000 live births in 2014, an 8 percent decline.  
//2013//

#### Division of Medicaid (DOM)

The mission of DOM is to ensure access to health services for the Medicaid eligible population in the most cost efficient and comprehensive manner possible and to continually pursue strategies for optimizing the accessibility and quality of health care. The DOM is a key partner in MS health care via reimbursement for services to patients seen in MSDH clinics. Medicaid and MSDH staff meet quarterly and, as needed, to discuss the progress and other concerns related to the Perinatal High Risk Maternity/Infant Service System (PHRM/ISS), Reproductive Health (formerly Family Planning) and Breast and Cervical Cancer Programs. In addition to a cooperative agreement, which allows billing for comprehensive enhanced services provided to PHRM/ISS and other non-high risk patients, the MSDH assists Medicaid in assessing pregnant women and children for Medicaid and SCHIP eligibility using MSDH staff and out-stationed eligibility workers.

The MSDH Office of Child and Adolescent Health collaborates with DOM to support the MS Youth Programs Around-the Clock (MYPAC), a home and community-based Medicaid waiver program that provides an array of services for youth with severe emotional disorders. The program provides alternate services to traditional Psychiatric Residential Treatment Facilities (PRTF) services. The Adolescent Health Coordinator collaborates with MS Division of Medicaid to promote the MYPAC program to MSDH staff in nine (9) Public Health Districts.

/2012/ The MSDH Office of Child and Adolescent Health collaborated with DOM, MYPAC staff to offer trainings on MYPAC and waiver programs for district and county health department staff in each public health district. //2012//

/2013/ MSDH is collaborating with DOM to address preterm birth and infant mortality in MS by addressing policy changes in areas such as partial reimbursement for high risk obstetrical care to stabilize and transfer pregnant women to maternal-fetal medicine specialists, non-payment of charges for non-medically indicated induction prior to 39 weeks gestation, and payment for 17P administration for high risk pregnancies. //2013//

#### MS Department of Mental Health

The MSDH collaborates with the MS Department of Mental Health, Division of Children and Youth Services to provide a comprehensive community-based mental health service system for children and adolescents. The Division serves as the lead agency responsible at the state level to improve the availability of and accessibility to appropriate, community-based service for children and youth with serious emotional disorders and their families. Recognizing the wide array of services needed by children and youth with serious emotional disorders, the MSDH, along with MS

Department of Mental Health and other key state agency partners, work to provide coordinated, cohesive system of care that is child-centered and family-centered through activities focusing on local and state infrastructure building, technical assistance to providers, and public awareness and education. A wraparound approach to delivery of services has been developed in an effort to make services accessible and appropriate for each child and family. A collaborative team of the MS Department of Mental Health Comprehensive Mental Health Centers, the State Level Case Review Team, several local Multidisciplinary Assessment and Planning (MAP) Teams, and other child-serving agencies and task forces assist children, youth and family access the system of care.

/2014/ The Department of Mental Health was awarded a planning grant to begin the initial phases of developing a system of care for early childhood mental health. //2014//

The State Level Case Review Team operates through an interagency authorization agreement to review cases of children and youth up to age 21 with serious emotional and behavioral problems and/or serious mental illness for whom adequate treatment and/or placement cannot be found at the county or local level, and for whom any single state agency has been unable to secure necessary services through its own resources. Before cases are referred to the State Level Case Review Team, all cases concerning children and youth (age 5 to 21) who have a serious emotional and/or behavioral disorder or serious mental illness and who are at immediate risk for an appropriate 24 hour institutional placement due to lack of access to or availability of needed services and supports in the home and community are reviewed by the Local-Level MAP Team. After having exhausted all available services and resources in the local community and/or in the state, cases are then referred to the State Level Case Review Team. This team consists of state agencies and private entities including MSDH, Mental Health, Education, Medicaid, Human Services, and the Attorney General's Office, and meets monthly to identify services used prior to referral, recommends modifications to these services, and develops alternate strategies to meet client need. Follow up monitoring of recommendations and clients are also activities of the State Level Case Review Team.

/2012/ The MSDH Office Director of Child and Adolescent Health serves on MS Advisory Council on Fetal Alcohol Spectrum Disorders (FASD) to prevent, educate, and bring awareness about birth defects and learning and behavioral disorders caused by prenatal alcohol exposure. The MSDH Office of Child and Adolescent Health collaborates with MS Department of Mental Health to offer trainings on FASD for district and county health department staff. //2012//

/2014/ Grant funding ended for the FASD project. However, the Advisory Council continues to meet to update and brainstorm on resources and training to build capacity around FASD. //2014//

/2013/ The MSDH Adolescent Health Program works closely with the MS Department of Mental Health and other community partners to strengthen Mississippi's System of Care (SOC). The Statewide Affinity Group (SWAG) was developed to provide an avenue for children and youth service providers, family and youth, and community stakeholders across the state to access treatment, intervention, and services through Mississippi's SOC. It is the goal of the SWAG to ensure resources and collaborations are fostered and supported to meet the needs of the children, youth, and young adults (ages 0-21) and their families in MS, thus creating a state of interdependence rather than independence.

The MSDH Office of Child and Adolescent Health collaborates with the MS Department of Public Safety to sponsor the Teens On The Move Summit, a safety and injury prevention event created by and for middle and high school students. The event focuses on reducing risk behaviors, promoting positive youth development, and building lifelong leadership skills. The Adolescent Health Coordinator offered health education resources for the 2011 MS Students Against Destructive Decisions (SADD) Club Officer Training. The prevention training was specifically designed for all newly appointed or elected leadership officers and service and safety clubs from across Mississippi. //2013//

/2014/ The MSDH Adolescent Health Program staff, along with MS Department of Mental Health and other community partners, collaborated with NFusion to build a successful award-winning Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two-Spirit (LGBTQI2-S) Integrity in Services and Support Conference targeted for Mississippi youth, families, and communities during November 2012. //2014//

**/2015/ The Office of Child and Adolescent Health was invited to participate in a regularly occurring LGBTQ Advocacy summit. //2015//**

#### Nutrition Services

The Nutrition Services program serves in an advisory capacity to internal and external programs. The primary focus is to encourage a healthier lifestyle by means of improved nutrition and increased physical activity throughout the agency and state by means of collaboration with relevant stakeholders.

The Department of Human Services (MDHS) partnered with MSDH to offer the Color Me Healthy program in the state. This program is for teachers in the preschool setting and targets incorporating food variety and physical activity using all five senses. Color Me Healthy also offers a component for parent education on nutrition and physical activity. The program was implemented on a limited basis in 2008. With the help of MDHS, Color Me Healthy toolkits have been purchased for every licensed child care center in MS to receive after completing training which is available throughout the state.

/2012/ The first year of Color Me Healthy training was completed and data are being evaluated to determine the effectiveness of the training. //2012//

/2013/ Color Me Healthy training continues. MS is the only state offering this free education opportunity for early child education facilities throughout the state. A poster was presented at the American Dietetic Association annual meeting in San Diego, CA, in September showing that the program has increased nutrition knowledge and increased physical activity in childcare centers. //2013//

**/2015/ Color Me Healthy training continues. Our nutrition guidelines were revised for the early childhood centers. Training is incorporated with Color Me Healthy. Our nutrition guidelines are stricter than those recommended through CDC and other organizations. //2015//**

Nutrition Services also works with the Child Nutrition Program in the Department of Education, the Department of Agriculture, and WIC to promote Fruits and Veggies-More Matters at school events, worksite wellness programs and education/health fairs. Our Fruits and Veggies-More Matters program reached over 15,000 individuals in 2009 and stresses the importance of including a variety of fruits and vegetables in the diet.

/2012/ Reached over 18,000 individuals in 2010. //2012//

Nutrition Services works with universities and colleges in precepting and training dietetic students. Each fall, the major universities invite Nutrition to participate in the orientation for new students. This is an opportunity to highlight the services provided by MSDH. Dietetic students are assigned preceptors for community nutrition in the clinics. Students are assigned to educate clients through individual counseling, WIC certification, and group classes. MSDH also hosts a "Genetics 101" conference for all students and professors annually. During the conference, students are introduced to the genetic and metabolic concerns that affect many of our children. Topics include processes to assist our children and their parents with dietary, emotional, and financial needs.

/2013/ The State MCH Epidemiologist added preconception health and lifecourse training to "Genetics 101" conference. //2013//

***/2015/ The "Genetics 101" conference was not held this year since the universities were restricting travel. The Nutrition Director went instead to each university and presented a condensed version in a class setting. With staffing changes and a reduction in patients we are contracting out the nutrition component to nutritionists and have arranged for them to attend a week long training at the University of Alabama. //2015//***

Nutrition Services works closely with the MS State Department of Education's Office of Healthy Schools to increase fruits and vegetables consumption and promote healthier lifestyles in an effort to decrease obesity. Funding allows for distribution of education materials, workshops, and assistance for schools and school wellness councils.

/2012/ Also works with MSDH Office of Nutrition, Physical Activity and Obesity. //2012//

***/2015/ The Nutrition Director has been involved within MSDH and with Departments of Education and Agriculture to increase gardens in the schools and working with Farm to School and Preschool. The MSDH website has a page to link farmers, schools, preschools, and businesses together for selling and purchasing fresh locally grown produce, and to link farmers to farmer's markets events. //2015//***

#### Preventive and Primary Care

MSDH provides funding and contracts with MS Federally Qualified Health Centers to increase access to preventive and primary care services for uninsured or medically indigent patients, and to create new services or augment existing services provided to uninsured or medically indigent patients. Services include, but are not limited to, primary care medical and preventive services, dental services, optometric services, in-house laboratory services, diagnostic services, pharmacy services, nutritional services, and social services.

#### Department of Public Safety

/2014/ The MSDH Office of Child and Adolescent Health provides age-appropriate health education resources and information related to behavioral health, alcohol and drug abuse prevention, safety and injury prevention, and positive youth development to Students Against Destructive Decisions (SADD) Chapters at middle and high schools. In April 2013, the Office of Child and Adolescent Health partnered with the MS Department of Public Safety and DREAM, Inc. to support middle and high school student leaders in organizing the Annual Teens On The Move Summit. //2014//

#### Office of Rural Health (ORH)

The MSDH ORH administers the Medicare Rural Hospital Flexibility (FLEX) Grant, which supports the provision of activities for Critical Access Hospitals. This program is designed to foster the growth of collaborative rural health delivery systems across the continuum of care at the community level with critical access hospitals as the hub of an organized system of care. This should result in improved access to care, economic performance and viability of rural hospitals, and ultimately, health status of the community. The Office of Rural Health contracts with the MS Hospital Association to provide additional staff support and programmatic assistance for the FLEX program.

#### MSDH STD/HIV

The STD/HIV office maintains sub-grants with ten community-based organizations, including

federally qualified health centers, and UMMC to provide STD/HIV prevention, awareness, care and services. These activities are targeted to populations at highest demonstrated risk. People living with HIV and African-American men and women are the three top priority populations in MS. The STD/HIV sub-grants address not becoming infected with STDs or HIV and the importance of routine HIV screening in general and during pregnancy. Using federal Ryan White funds, the STD/HIV office provides funding for statewide medical case management, including direct care, for HIV-infected pregnant women and labor and delivery guidance and follow-up. Women with HIV infection eligible for the AIDS drug assistance program may receive dental care at an MSDH dental clinic at no cost to the woman (an example of MSDH provided direct care for those living with HIV infection). The pediatric infectious disease sub-grant also pays for statewide medical case management of perinatally-exposed infants until they are deemed HIV negative and for perinatally-infected infants until they are at least 18 years old. At this time they are transferred to UMMC Adolescent and Adult Infectious services - also funded to provide additional services through Ryan White pass-through money.

//2014/ The STD/HIV Office maintains sub-grants with twenty community-based organizations, federally qualified health centers, colleges/universities, alcohol and drug treatment centers, and UMMC to provide STD/HIV prevention, awareness, care and services. //2014//

## WIC

The Office of WIC has a contractual relationship with 12 community health centers and one hospital for the purpose of certification of women, infants, and children for provision of WIC food packages through the 96 food centers located throughout the state.

## F. Health Systems Capacity Indicators

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Indicator	85.8	87.6	87.4	86.8	86.8
Numerator	38381	34884	34680	33407	33407
Denominator	44734	39836	39695	38499	38499
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

### Notes - 2013

Note: The MS Vital Records and statistics 2013 data will be released in Fall of 2014. The most recent data available for this indicator 2012 data.

### Notes - 2012

Note: The MS Vital Records and statistics 2013 data will be released in Fall of 2014. The most recent data available for this indicator 2012 data.

## Narrative:

The PHRM/ISS program has begun to collect data regarding date of entry into prenatal care to use for program analysis and to develop strategies for improvement.

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	55.0	58.6	58.7	57.4	60.1
Numerator	45274	50522	51616	52167	57646
Denominator	82295	86224	87927	90876	95840
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2013**

Note for report of 2013 data: Data provided by State of Mississippi, Division of Medicaid

**Notes - 2012**

Data provided by Department of Health and Human Services, Centers For Medicare and Medicaid Services, Federal Form CMS-416, Line 12A (Total eligible receiving a dental service) and line 1 (Individuals eligible for EPSDT).

**Notes - 2011**

Note for report of 2011 data: Data provided by State of Mississippi, Division of Medicaid

**Narrative:**

In September 2013, the Office of Oral Health received the State Oral Health Program Grant from the Centers of Disease Control (CDC) and Prevention. These funds allowed the program to hire additional staff to increase program efforts. An epidemiologist was recently hired to develop an oral health surveillance system. Recruitment efforts to identify a sealant program manager and a program coordinator are underway.

Regional oral health consultants provide program support at the local level. They are assigned by region to cover their territories to provide dental sealants and fluoride varnish.

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 08 - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	3.7	3.1	2.3	2.1	2.1
Numerator	759	642	477	440	440
Denominator	20340	20589	20769	20900	20811
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

#### Notes - 2013

Note for 2013: No updated data has been provided at this time.

#### Narrative:

The Children's Medical Program (CMP) collaborates with Medicaid, the Social Security Administration (SSA), and other third party payers to assure access to needed services for children with special health care needs. Information regarding Medicaid and SSI is sent to each new CMP beneficiary. In the past, CMP's information has been made available through the Social Security Administration's SSI Division encouraging all beneficiaries to apply for CMP services to determine eligibility for program medical and/or information services. However, all SSI beneficiaries may not directly receive rehabilitative services through the CSHCN program due to differences in eligibility criteria for program enrollment. As of December 2012 which are the latest statistics available through the Social Security Administration (SSA), there were 1,643 Mississippi children under the age of 16 receiving SSI benefits, which represents 6.8% of the total state SSI beneficiaries. Of the total number of active CMP enrollees, there were 2,037 enrollees under the age of 16 in this time period, of which 371 were SSI beneficiaries. The latest available statistics on the Social Security Administration's website for Mississippi's SSI recipients indicates that as of 2012 there were a total of 126,642 SSI recipients of which 9,910 were aged and 116,732 were either blind or disabled (not all qualified for program services). Of that total, 24,194 were under age 18; 77,991 were age 18 to 64 and 24,457 were age 65 or older. To better inform patients and their families of needed resources and to assist patients in their self-advocacy efforts and transition to adult care, CMP's relationship with SSI has changed. The SSA liaison designated to work with CMP tentatively agreed to assist CMP in providing SSI eligibility and other related program information to CMP patients and their families during several of CMP's Information and Education Sessions, as well as during CMP's bi-annual Resource Fair, but her involvement was impacted by temporary budget cuts that placed a freeze on travel and limited the number of community outreach activities allowed. Yet, the relationship continues. The annual or bi-annual program-sponsored Resource Fair serves as a specialized one-stop-shop resource outlet and is one of several gap-filling services the program offers to patients and their families in an effort to assist them in navigating through systems of care, transition, and to educate them about currently available resources pertinent to their disability.

#### Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2012	other	13.4	10.1	11.6

#### Notes - 2015

Note: Medicaid data from 2013, Vital Records data from 2012 used to calculate totals and percentages.

**Narrative:**

The PHRM/ISS program is collecting data regarding weights of babies born to high risk pregnant women, date of entry into prenatal care, and negative outcomes. This data is being collected on the participants in PHRM/ISS for program analysis. Infant that are born low birth weight or very low birth weight are offered the PHRM/ISS program where case managers assists the mother in keeping appointments and monitors infant weight for progress.

**Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births***

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2012	other	4.3	16.6	8.8

**Notes - 2015**

Note: Medicaid data from 2013, Vital Records data from 2012 used to calculate totals and percentages.

**Narrative:**

In 2013, the Sudden Infant Death Syndrome (SIDS) Program partnered with internal and external programs at nine community events targeting childcare workers, nurses, parents, and stakeholders. The MSDH SIDS program provided educational materials to childcare facilities, faith and community base organizations. Other activity during the year includes adding SIDS awareness information in the Childcare Licensure Newsletter and a news release on the MSDH's social media sites (i.e., Facebook, Twitter). The program mailed approximately 48,000 brochures to hospitals statewide entitled: What a Safe Sleep Environment Looks Like, Baby's Safe Sleep Crib Checklist, and Creating a Safe Sleep Environment for Baby.

By December 2014, efforts will be made to increase infant safe sleep practices by 5 percent. In order to accomplish this goal a partnership will be developed with the Mississippi State Fire Marshal's office to provide Direct On Site Education SIDS training for firefighters. Through this training, firefighters will gain knowledge about SIDS, be able to identify a safe sleep environment, and provide SIDS education to families whose homes they visit with a child less than one year of age. Initiatives will also be implemented to incorporate standard SIDS education into the PHRM Partner's for Healthy Babies Curriculum. MSDH partnered with the MS SIDS Alliance and the Cribs for Kids Program during 2013 to distribute 46 cribs to families identified with an infant less than one year of age with an unsafe sleep environment. The SIDS Program collaborated with the Newborn Screening Program to conduct a survey that incorporated the four PRAMS questions related to safe sleep. The results of the survey are being analyzed.

The SIDS Program will continue to identify best practices from other states to help reduce SIDS deaths and infant mortality. In collaboration with the Child Death Review Panel, the SIDS Program will continue to promote safety among children.

**Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.***

DATA SOURCES	Does your state participate in the YRBS	Does your MCH program have direct access to the state YRBS database for
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	<b>survey? (Select 1 - 3)</b>	<b>analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	3	Yes

#### **Notes - 2015**

##### **Narrative:**

Seventy-eight cities and towns have passed comprehensive smoke-free air ordinances. Previous efforts to pass a statewide smoke-free air law have been unsuccessful. The MSDH Office of Tobacco Control (OTC) will continue to work with partners to inform Mississippians about the benefits of smoke-free air and the harmful effects of exposure to secondhand smoke.

The MSDH OTC is currently working with partners to engage youth in grades 7-12 in more grassroots tobacco prevention and advocacy activities statewide. The Leadership, Engagement, and Activism Development (L.E.A.D.) conferences for youth in grades 9-12 were held this year with more than 766 high school students participating in the events. Students attending the L.E.A.D. conferences learned leadership and advocacy skills and strategies to create change in their communities related to reducing youth tobacco use. Skills gained from the conferences will be used by tobacco control program teams and youth involved with the Mississippi Tobacco-Free Coalitions.

Additional youth events held to inspire leadership and promote advocacy include SMART trainings (Students Mobilizing through Advocacy to Reshape Tomorrow) for students in 10th-12th grades and iFLY conferences (Inspiring Future Leaders Youth) for students in 7th-8th grades.

The MSDH OTC provided funding to 33 Mississippi Tobacco-Free Coalitions (MTFC) to work in all 82 counties to implement tobacco control programs at grassroots levels. Each MTFC conducted tobacco control programmatic and awareness activities throughout the year that contained messages for youth and adults. The MTFCs worked to increase tobacco-free policies in municipalities statewide and promoted the use of tobacco prevention curricula in schools.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

In an effort to carry out the core functions of public health, the MSDH relies on the work of public health team members across the state to assist every community in the state to achieve the best possible health status for its citizens. The MSDH accomplishes this through the agency's goals of:

(1) Assessing health status indicators of the state's population to document each community's health needs and conduct epidemiological and other studies of specific health problems; (2) Developing, promoting, and supporting public policy and strategies that protect the state's citizens from unsanitary conditions related to the environment and that emphasize healthy lifestyles and the prevention of morbidity and mortality associated with disease and illness; and (3) Assuring access to essential health services.

MSDH Health Services (HS), through the Office of Women's Health and the Office of Child/Adolescent Health Services, administers programs that provide services for the three major populations targeted by the MCH Block Grant: women and infants, children and adolescents, and children with special health care needs (CSHCN). Clinical and support services are provided to the target populations through local county health departments and specialty clinics. Services include prenatal and postnatal care, case management for high risk pregnant and postpartum women and infants, well child and limited sick child care, as well as restorative services for CSHCN. This network allows the MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

The MSDH Child Health and Prenatal programs serve all women, infants, and children but target services to women, infants, and children at or below 185 percent of poverty. Services are preventive in nature; however, treatment is often included for those whose need is greatest. Using a multi-disciplinary team approach, including medical, nursing, nutrition and social work, the Child Health Program provides childhood immunizations, well child assessments, limited sick child care, and tracking of infants and other high risk children. Services provided are basically preventive and designed for early identification of health concerns. Case management services are provided to high risk pregnant and postpartum women and infants by nurses, social workers and nutritionists. Services are provided in clinics and in the clients' homes.

In areas where the MSDH is not the primary provider of care, the MSDH contracts and/or collaborates with private providers to care for the MCH and CSHCN population. Some of these providers conduct regular and/or screening clinics in health department facilities. Others are contracted for consultation and referrals. The MSDH provides support services such as case management, nutrition and psychosocial counseling, education and nursing.

In some areas of the state, prenatal patients are seen in health department clinics for 28-34 weeks. After delivery, these clients return to MSDH for postpartum and family planning services. All high risk patients are referred to private physicians for continued care.

In other parts of the state, the health department has contractual agreements with private providers whereby the MSDH manages the patient until a certain stage of gestation and then transfers the patient to the private provider for the remainder of her care. There are several areas of the state where, when a patient's pregnancy is confirmed, she goes immediately into the private sector or to a community health center or rural health clinic for care.

The MSDH, in administering the Title V programs, has taken steps to integrate the private medical community into the system through contractual arrangements whereby local physicians provide limited clinical coverage at local health departments. These physicians enhance the

continuum of care by becoming the client's provider of after-hours and weekend care when necessary and many times provide a medical home for families as the family's economic status improves.

#### /2013/ Logic Model Activities

Mississippi is enhancing its effort to plan evidence-based public health interventions. In February 2012, the State MCH Epidemiologist, Children's Medical Program Director, and Director of Program Development & Effectiveness attended an AMCHP Annual Conference skills-building session titled "Identifying Evidence-Based Practices that Lead to Improvements in MCHB Performance Measures: A Toolkit for States". The session provided strategies for selecting and evaluating evidence-based program activities aligned with Title V performance measures via logic models. The team began creating a logic model of program activities for Title V National Performance Measure 6 while at the workshop. Following the conference, the Title V Coordinator and Title V Epidemiologist met with the State MCH Epidemiologist for an update on AMCHP activities. In this grant cycle, we plan to use the preliminary work with NPM 6 to complete a pilot run of linking evidence-based activities to performance measures through logic models. Our ultimate goal is to assess all performance measures appropriate for this type of planning, and create logic models for these measures by the end of the five year grant cycle. //2013//

/2014/ The Children's Medical Program Director completed logic models for Title V National Performance Measures 2-6. The logic models are included as an attachment to this section. //2014//

#### Fetal Infant Mortality Review (FIMR) - Coastal Pilot Project

As a result of Mississippi's high infant mortality rates, a FIMR Program is being implemented by MSDH in the Gulf Coast District IX counties (Harrison, Hancock, Jackson, George, Stone and Pearl River counties). The Fetal and Infant Mortality Review (FIMR) program is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants and families. This is a regional review that looks at the psycho-social issues, prenatal care adequacy, transportation, domestic violence, tobacco use, and poverty, for example, that may impact poor birth outcomes.

/2013/ Mississippi's FIMR program is being implemented by a Master's prepared RN who retired from the Louisiana Department of Health and Hospitals (LDHH). One of her many accomplishments at LDHH was implementation of a statewide FIMR program in Louisiana, making her an excellent resource for implementing FIMR activities in Mississippi. Record abstractions are being conducted by an RN with practice background in Labor & Delivery and High Risk Prenatal Care.

During March and April 2012, the Mississippi FIMR team and planners traveled to Alexandria Louisiana to receive face-to-face training, advice, and support from nurses who conduct the FIMR in their region of Louisiana. A "kick-off" event for the FIMR pilot program was conducted on May 31st, 2012. More than 100 participants attended the event to hear information about Mississippi infant mortality and learn more about the FIMR process and how it will benefit Mississippi infants. //2013//

/2014/ Focus to date has been on Case Review Team (CRT) recommendations, which have been mostly about improving physician practice, hospital policies and procedures such as standardized grief counseling/support, SIDS and safe sleep instruction to prenatal and postpartum women, tobacco cessation resources, car seat safety, and family planning services through MSDH. The Community Action Team (CAT) focus within the community- and faith-based groups has been on increasing awareness of the issues impacting poor birth outcomes through speakers on the same topics. To date, 78 individuals are represented on the CRT and 95 on the CAT. CRT meeting numbers, depending upon location, range between 22 and 45 participants while the CAT meeting

numbers range between 25 and 40. //2014//

***/2015/ As of 1/1/14, 50 cases were abstracted by the RN coordinator and presented to a total of 101 medical providers, coroners, pharmacists, pathologists representing 8 regional birthing hospitals, and District IX public health representatives. The medical Case Review Team (CRT) monthly meeting recommendations were implemented both internally to hospitals and public health, and to the FIMR Community Action Team (CAT), composed of more than 50 community groups.***

***Future directions include: development of additional Community Action Teams within the rural areas, focusing on faith-based groups, pediatricians, coroners, and funeral homes. FIMR developed a collaborating committee that includes 8 coastal hospital Maternal and Child Health Nurse Directors/Managers and public health in order to implement recommendations.***

***Findings from the review of the 50 cases show that 76 percent of the mothers were single, 64 percent were unemployed, 78 percent were eligible for Medicaid, 38 percent were smokers, and 16 percent were exposed to second hand smoke. //2015//***

## **B. State Priorities**

The following issues were adopted as the priority needs for the maternal child health programs and the new 5-year cycle of the Title V MCH Block Grant. A measurable state performance indicator has been established for each of the priority issues, a data source identified, and base line data extracted. The new state performance measures were entered into the appropriate forms within the TVIS block grant application.

/2014/ After much deliberation by the Mississippi Title V MCH Block Grant Work Group, a group comprised of maternal and child health stakeholders, who guide the Title V application process, made a unanimous decision to delete bullying as a listed priority and add preconception and interconception care as standalone priorities. Bullying will continue to be addressed by MSDH programs and their partners and is viewed as an important issue with far reaching consequences but there were too few data to substantiate a program or indicator and to inform progress toward stated goals.

Preconception care was previously listed with low birthweight and preterm birth but has now been separated out and combined with interconception care. Maternal health before, during and after pregnancy is a significant contributor to both maternal and infant morbidity and mortality. Adequate birth spacing allows for women to improve health and social risk factors and improves outcomes in pregnancy and for developing children. State Performance Measure 11 was adopted to capture data around pregnancy spacing and describe programmatic activities that encourage healthy family planning practices. //2014//

1. Low birthweight and preterm birth
2. Preconception and interconception care
3. Teen pregnancy and teen birth rate
4. Nutrition and physical activity
5. Adolescent alcohol and drug use
6. Sexually transmitted disease
7. Adult immunizations

Goals to address these priority issues are listed within the state measure detail sheets on Form 16. The following list summarizes the goals and significance of each priority and measure.

\*To reduce the occurrence of very low birthweight deliveries in Mississippi: Very low birthweight deliveries account for more than half of Mississippi infant deaths.

\*To increase preconception care and interconception care and healthy birth spacing.

\*To reduce the rate of teen pregnancy among adolescents aged 15-19 years: Mississippi leads the nation in adolescent births.

\*To reduce adolescent and childhood overweight and obesity: Mississippi leads the nation in obesity.

\*To reduce tobacco use among adolescents: Tobacco use is highly associated with prevalence of cancer.

\*To reduce adolescent use of alcohol and illegal drugs: Mississippi has a high rate of unintentional injuries

\*To reduce the rate of sexually transmitted disease; Mississippi has a high prevalence of sexually transmitted disease.

\*To increase adult immunizations; immunizations are primary disease prevention.

\*To reduce occurrence of repeat preterm or small-for-gestational-age infants: Previous negative birth outcomes are a predictor of risk for negative birth outcomes among subsequent pregnancies. Mississippi leads the nation in prematurity and low birthweight.

The new state performance measures were selected to evaluate progress towards improving the state priority issues. The new state performance measures were constructed with minimal overlap with national performance measures. The state's capacity and resource capability for addressing these issues is discussed in detail within our State Overview under Section III. Specific details of Organizational Structure and Capacity can be found within Section III. Items B, C, and D. The new state performance measures drawn from the state priorities listed above are.

1. Percent of infants born with birthweight less than 1,500 grams.
2. Rate of pregnancy per 1,000 female adolescents aged 15-19 years.
3. Percent of students in grades 9-12 who met recommended levels of physical activity.
4. Percent of students in grades 9-12 who reported current cigarette use, current smokeless tobacco use, or current cigar use.
5. Percent of students in grades 9-12 who reported current alcohol, marijuana or cocaine use.
6. Percent of students in grades 9-12 who had ever been bullied on school property during the past 12 months. (DEACTIVATED)
7. Rate of Chlamydia, gonorrhea, and syphilis cases per 100,000 women aged 13-44 years.
8. Percent of women aged 18-44 years who received an influenza vaccination within the last year.
9. Percent of women having a live birth who had a previous preterm or small-for-gestational-age infant.
10. The percentage of births with interpregnancy interval less than 18 months. (DEACTIVATED: Never used.)
11. The percent of women whose live birth occurred less than 24 months after a prior birth.

/2014/ Collaborative Improvement and Innovation Network (CoIIN)

As a result of Mississippi's high infant mortality rate, in 2011 Mississippi developed a State Infant Mortality Task Force comprised of representatives from the Mississippi State Department of Health (MSDH), Medicaid, March of Dimes, University of Mississippi Medical Center (UMMC), and the American Academy of Pediatrics. This group participated in the Region IV and VI Infant Mortality, Preterm Birth, Prematurity Summit in New Orleans in January 2012 at which 13

southern states developed plans to reduce infant mortality. At a follow up meeting in July in Washington DC, HRSA MCHB, in partnership with AMCHP, ASTHO, the March of Dimes, CityMatCH, and federal partners, including CDC and CMS, launched the Collaborative Improvement and Innovation Network (CoIIN) to facilitate collaborative learning and adoption of proven quality improvement principles and practices across the 13 southern states of Regions IV and VI. //2014//

***/2015/ Building upon the CoIIN, Mississippi has continued to focus on the following areas to improve perinatal outcomes and reduce infant mortality: 1) eliminate elective deliveries prior to 39 weeks gestation, 2) decrease smoking and second-hand smoke exposure for pregnant women, infants and children, 3) promote safe sleep environments for infants, 4) improve preconception health and interconception care for women 5) strengthen regional perinatal care systems and 6) increase access and use of 17-alpha hydroxyprogesterone caproate (17-P) to prevent preterm births. Mississippi has dedicated work groups based at MSDH composed of stakeholders and organizations from across the state that identify and execute strategies to improve each of these areas of focus.***

***During 2013 and the first quarter of 2014 there has been considerable progress in all areas. All groups have focused upon collecting and evaluating existing data and the agency has prioritized improving access to real time data. Mississippi received SSDI CoIIN funds to enhance access to high quality, timely data. Through this effort MSDH has reported quarterly process measures for the first time. With this \$25,000 CoIIN grant MSDH accomplished the following activities:***

- 1) Improved the online data access program 'Mississippi Statistically Automated Health Resource System' to include CoIIN measures that can now be searched by county, race, and year***
- 2) Development of a Perinatal Health webpage to update stakeholders and the public about improved efforts at: [msdh.ms.gov/perinatal](http://msdh.ms.gov/perinatal);***
- 3) Funded the purchase of a OneHub subscription for in-state partners to share resources;***
- 4) Support linkage of Medicaid claims and vital statistics data;***
- 5) Grant support to the March of Dimes to collect data from Mississippi hospitals regarding early elective deliveries;***
- 6) Funded the production of reports on maternal and infant health for public and partner distribution.***

***Across all of the CoIIN groups there has been a focus on working collectively and finding opportunities to streamline and integrate the various initiatives across the state. Below are some of the notable accomplishments of each group.***

- 1) Early Elective Delivery: Leadership from MSDH partnered with the MS Chapter of the March of Dimes; Mississippi Section - American Congress of Obstetricians and Gynecologists; The Association of Women's Health, Obstetric and Neonatal Nurses; and the Mississippi Hospital Association to request that all obstetric hospitals pledge to reduce early elective deliveries. Those hospitals that instituted a hard stop policy reduced rates to less than 5% were able to receive a quality recognition banner. To date 37 of the 44 obstetric hospitals, covering over 85% of all deliveries, have signed the pledge and six hospitals have qualified for the pledge. We have seen an over 33% reduction in early elective deliveries since 2011.***
- 2) Tobacco Cessation: The Division of Tobacco Control has partnered with Health Services to integrate tobacco control education across the SIDS Program, Fetal Infant Mortality Review. MSDH has successfully been awarded grant from the March of Dimes to train nursing educators across the state in the Smoking Cessation and Reduction in Pregnancy Training program. We have worked to expand referrals of pregnant women to the Quit Line and have trained providers across the state in Federally Qualified Health Centers.***

**3) Safe Sleep: The Safe Sleep team has continued education and outreach across the state. MSDH has shared its training program with hospitals in order for those trainings to be incorporated into mandatory staff education. Materials are shared with churches, day cares, providers and community groups. We have partnered with the Mississippi SIDS Alliance to broaden education efforts across the state. In the coming year we will work to standardize coroner training about SIDS and SUID and improve daycare and hospital safe sleep policies.**

**4) Interconception Care: Expanding the Pregnancy High Risk Management program for women with a high risk pregnancy outcome. Establishing plans to work with Medicaid to improve post-partum and well-woman care to enhance interconception health.**

**5) Perinatal Systems of Care: Adopted AAP guidelines for Perinatal Levels of Care into the State Health Plan and worked with CDC to develop a hospital assessment.**

**6) 17P Established a system to provide 17P to all eligible health department patients.**

**7) Breastfeeding: We will expand our workgroups to include taskforces to improve breastfeeding in Mississippi in 2015. We will work to build stakeholder support and reevaluate health policies and practices to support breastfeeding across the state.**

***In this coming year MSDH will provide leadership for the successful execution of the initiatives supported by the COIIN. There will be a strategic focus on developing evidence based health policies across the state and targeting quality performance measures in perinatal health in order to create sustainable improvements in maternal and infant health in Mississippi. //2015//***

#### Personal Responsibility Education Program

The Mississippi State Department of Health (MSDH) has been selected as the recipient of \$2,148,872 in funding from the Personal Responsibility Education Program (PREP), financed under the Affordable Care Act and administered by the Administration for Children and Families. Mississippi is one of 46 states to receive a grant from this program. The funds will be used to implement a new comprehensive teen pregnancy prevention program. The program will work with individual school districts to create customized intervention and education programs addressing the prevention of teen pregnancy and sexually transmitted disease. The purpose of PREP is to carry out personal responsibility education programs designed to educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS.

*//2014/ Mississippi leads the nation in per capita teen births, with more than 83 percent of teen pregnancies unintended. A third of all Mississippi births are to teen mothers. Each year, the MS Department of Human Resources receives \$824,000 in Title V funding aimed at promoting abstinence among teenagers. As of June 2012, 81 public school districts adopted an abstinence-only program and 71 school districts adopted an abstinence-plus program. Thirty-three of the 71 school districts received direct funding support from the PREP grant program to implement the abstinence-plus program. As of March 2013, a total of 5,838 youth have received educational services. The PREP grant received a \$25,000 award from Advocates for Youth for a School Health Equity Project designed to establish and improve access to youth friendly health services. The project initiated a larger collaboration between the University of Mississippi Medical Center and Women's Fund of MS to establish the state's first dedicated youth-friendly clinic "Midtown Teen Wellness Center." Youth-friendly services are low-cost, confidential, and accessible to young people. //2014//*

***//2015/ During the second year of program implementation, the PREP program continued implementation within priority school districts, expanding implementation within eligible instructional grades of participating districts, increasing service capacity of CBOs and expanding educational outreach in underserved communities. As of June 2013, a total of 32 school districts received funding support from the PREP grant program to continue implementation of abstinence-plus programs. PREP also re-funded two community-based***

**organizations to continue implementation of comprehensive sex education. As of March 2014, a total of 10,118 youth have received educational services. As previously reported, the PREP program received an award from Advocates for Youth to fund the School Health Equity Project with the purpose of establishing /improving youth friendly sexual health services in Jackson, MS. Since the clinic has opened, a total of 100 youth have received comprehensive health services. //2015//**

#### Obesity/Physical Activity Efforts

/2012/ Legislative efforts to Address Obesity-House Bill 1170 passed and became law and authorizes a six-month study to examine the availability of healthy foods, fresh fruits and vegetables to Mississippians. More than two-thirds of the state's counties - including Hinds, Madison and Rankin (metropolitan Jackson) - contain food deserts, where these fresh foods are hard to find. Those living in these areas are more likely to suffer from obesity and other health problems, such as diabetes, cancer and heart attacks.

The Center for Mississippi Health Policy contracted with three universities to evaluate the Mississippi Healthy Students Act. This act, passed in the 2007 legislative session, requires public schools to provide increased amounts of physical activity and health education instruction for K-12 students. The Act mandates 45 minutes per week of health education instruction and 150 minutes per week of activity based instruction in Grades K-8. Key findings showed that fitness is strongly associated with academic performance and school attendance and parents do not recognize when their child is obese. The policy implications of the evaluation indicate the need to strengthen the quality of physical education programs and increase opportunities for physical activity. //2012//

/2014/ Move To Learn is an initiative designed to help teachers raise student fitness levels and raise student achievement. Spearheaded by The Bower Foundation and the Mississippi Department of Education, Move To Learn provides K-6 teachers five-minute videos featuring a physical education teacher leading students in simple exercises that can be performed in the classroom. Read more on this initiative in State Performance Measure 3 for this year.

State school officials have implemented a new tool to battle childhood obesity, the combi-oven. The appliance is a cross between a steamer and an oven and cuts out frying without the fatty oils. One oven costs about \$18,000 and most schools actually need two. The Bower Foundation, a Mississippi based private philanthropic organization focused on health improvements within the state, recently announced \$900,000 in grants for schools to buy combi-ovens. School districts must contribute half of the money as part of the deal and they must agree to remove all fryers. //2014//

**/2015/ In 2013, the MDE Office of Healthy Schools and the MSDH Office of Preventive Health collaborated to host 11 professional development trainings on nutrition and physical activity throughout the state. A total of 463 participants were trained utilizing the Move to Learn, School Health Index, and Mike Kuczala's Kinesthetic Classroom physical education curriculum and instruction.**

**The MSDH Office of Preventive Health will continue its partnership with MDE to conduct professional development activities and provide technical assistance to school and public health district staff regarding evidence-based strategies that promote recess, multi-component physical education policies, and sodium reduction practices. Additional professional development and technical assistance opportunities will be provided by the MSDH Office of Preventive Health, Office of Child Care Facilities Licensure and MDE to early childhood education (ECE) center staff regarding implementing physical activity strategies, regulations, and policies. //2015//**

#### Office of Tobacco Control (OTC)



The mission of the MSDH OTC is to promote and protect the health of all Mississippians by reducing tobacco-related morbidity and mortality. The program accomplishes this by utilizing a systemic approach to tobacco prevention and control. Program components include: state and community interventions, health communication interventions, tobacco cessation interventions and surveillance and evaluation. Each program component is developed and implemented based on evidence-based strategies and the recommendations outlined in CDC Best Practices-2007.

Since its inception in July 2007, the MSDH OTC has worked diligently to develop the statewide and comprehensive tobacco education, prevention and cessation program. Through CDC Cooperative Agreement funds, the program has partnered with the MSDH Office of Preventive Health, Chronic Disease Bureau, to establish chronic disease coalitions that educate communities on cardiovascular disease, diabetes, asthma and tobacco use. The program has furthered its efforts to enhance established coalitions and strengthen partnerships by supporting the MSDH/American Lung Association of Mississippi's district-level asthma coalitions and partnering with MSDH Oral Health to promote tobacco cessation programs and awareness of the health risks associated with second-hand smoke exposure in Head Start. Other partnerships include collaboration with WIC to distribute tobacco awareness brochures; WIC certifiers also discuss smoking related issues with applicants.

/2012/ New FY 12 partnerships to coordinate trainings for healthcare providers to utilize the 5As approach to tobacco cessation include the MS Rural Health Association, MS Nurses Foundation, MS Primary Care Association, MS Family Physicians Foundation and the MS Chapter of the American Academy of Pediatrics. //2012//

/2014/ The MSDH OTC partnered with the Substance Abuse and Mental Health Services Administration, the Smoking Cessation Leadership Center, and the Institute for Disability Studies at the University of Southern Mississippi to develop a strategic plan that will address nicotine addiction among behavioral health consumers and staff. The intent is to identify tobacco-related disparities among mental health patients and to create an environment of collaboration and cooperation among the fields of public health, mental health, and addictions.

The MSDH OTC continues to work with the MSDH Office of Childcare Licensure and the Office of Oral Health to promote Care for Their Air, a program that provides education about the harmful effects of exposure to secondhand smoke. Training and outreach are provided to child care directors and staff who work closely with parents, children, and babies. Those who participate acquire knowledge, skills, and resources to educate parents and children about the health benefits of becoming smoke-free.

In FY13, the MSDH OTC partnered with the MS Primary Healthcare Association to provide training and technical support to three pilot sites to conduct in-house tobacco dependence treatment programs. The target clinics are GA Carmichael in Canton, MS; Greater Meridian Health Center in Meridian, MS; and Jefferson Comprehensive Health Center in Fayette, MS.

In FY 2013, the MSDH OTC continued its partnership with MDOC to provide technical assistance and training to healthcare providers at MDOC facilities on implementing a tobacco-free policy. The Office of Tobacco Control coordinated trainings for MDOC healthcare providers on implementing tobacco cessation interventions with the offender population and provided trainings for MDOC staff on the dangers of tobacco use, the benefits of not using tobacco, and making referrals for tobacco dependence treatment services.

In FY 2013, the MSDH OTC continued its partnership with MDOC to provide technical assistance and training to healthcare providers at MDOC facilities on implementing a tobacco-free policy.

In FY 2013, the MSDH OTC partnered with the Department of Mental Health to provide trainings to healthcare providers on tobacco dependence treatment and referrals for mental health and

substance abuse patients. //2014//

MSDH is leading a statewide campaign to educate Mississippians about the dangers of secondhand smoke. The goal is to complete a two-year campaign that will inform Mississippians about the benefits of smoke-free air, educate residents about the harmful effects of breathing secondhand smoke, and support a comprehensive statewide smoke-free air law.

In order to reduce the estimated 5,250 premature deaths, including 550 deaths among nonsmokers as a result of secondhand smoke, MS health advocate organizations are partnering with MSDH to help with the Smoke Free Air MS campaign. The campaign will include extensive grassroots efforts, a statewide media campaign, and collaboration with key partners to support the passage of a comprehensive smoke-free air law.

***/2015/ Seventy-eight cities and towns have passed comprehensive smoke-free air ordinances. Previous efforts to pass a statewide smoke-free air law have been unsuccessful. The MSDH Office of Tobacco Control (OTC) will continue to work with partners to inform Mississippians about the benefits of smoke-free air and the harmful effects of exposure to secondhand smoke. //2015//***

*/2012/ A bill to prohibit smoking in all public places died during the 2011 legislative session. //2012//*

*/2013/ A bill to prohibit smoking in all public places died during the 2012 legislative session. //2013//*

***/2015/ Bills to prohibit smoking in public, enclosed locations with exceptions for certain businesses were introduced. A public hearing was held on the issue; however, SB 2171 & HB 656, relating to prohibition of smoking in all public places, and SB 2607 & HB 739, relating to enacting the Mississippi Smoke-free Air Act of 2014 died on February 4th.***

***HB 1250, a bill to increase the excise tax on cigarettes, died in committee on 2/26/2014. //2015//***

A recent study by MS State University researchers in two MS towns, Starkville and Hattiesburg, showed respective decreases of 27.7 and 13.4 percent in heart attack hospital admissions after implementation of smoke-free air ordinances. The study focused on residents in the three-year span after the laws went into effect compared to three years prior (53 admissions before and 38 after in Starkville; 345 admissions before and 299 after in Hattiesburg). It is hoped that similar decreases would be realized with the passage of a statewide smoke-free air law.

***An attachment is included in this section. IVB - State Priorities***

## **C. National Performance Measures**

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	108	109	114	91	100
Denominator	108	109	114	91	100

Data Source	MSDH - Genetics Program	MSDH - Genetics Program	MSDH - Genetics Program	MSDH - Genetics Program	MSDH - Genetics Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	100	100	100	100	100

#### **a. Last Year's Accomplishments**

During CY 2013 97 newborns were confirmed with a genetic disease/disorder through the newborn screening program. Follow-up, counseling and referral for a medical evaluation and treatment were provided for 100 percent (97) of the babies detected with a genetic disorder. The teams in the public health districts coordinate with county staff to follow up on presumptive positive screening results. The coordination of newborn screening follow-up includes: facilitation, evaluation, diagnosis, management, and education, all of which are essential public health activities that contribute to the success of this population-based screening program. The Genetic Services program staff attended several national conferences including the 2013 Joint Meeting of Newborn Screening and Genetic Testing Symposium and the International Society for Neonatal Screening and APHL -- Legal and public Health Perspective Surrounding Residual Dried Blood Spots in Newborn Screening. The Genetic Services staff completed an evaluation of the Child Health Long-term Care database to ensure children identified through newborn screening with a disorder/disease are in a system of care and receiving the services they need post newborn screening diagnosis and short-term follow-up. The staff conducted an evaluation of state newborn screening programs implementation or readiness to implement CCHD screening to assist the state in determining implementation strategies for including additional disorders. The Genetics program staff provided in-services for all birthing hospitals to improve specimen collection and handling and other newborn screening procedures.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide screening of all births occurring in the state and follow-up on all inconclusive, abnormal, and presumptive positive results			X	
2. Provide family counseling and arrange for repeat screens for all babies with inconclusive and abnormal results, and arrange for diagnostic evaluations for all babies with presumptive positive results		X		
3. Identify all confirmed cases of genetic disorders detected through the screening process		X		
4. Assure that children diagnosed with genetic disorders have a local medical home and are receiving appropriate treatment and		X		

follow-up				
5. Continue to assist in coordinating the case management of affected children with local health departments and physicians		X		
6. Encourage and establish more local support networks for families and patients		X		
7. Identify and collaborate with more resources to support patients and families across the lifespan		X		
8.				
9.				
10.				

#### **b. Current Activities**

The program's current activities include on-going education on the importance of newborn screening and follow up. The program staff provides pediatric clinicians and hospitals with educational materials to increase their awareness about genetic disorders/diseases and the role of public health staff in the short and long term follow up for children identified with genetic conditions. Emphasis is placed on assuring that children have a local medical home as defined by the American Academy of Pediatrics (AAP). The AAP definition of Medical Home Model is where families receive primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youth, including children and youth with special health care needs. The Genetic Services Program collaborates with the Children's Medical Program, Early Intervention, Early Hearing Screening Program, and other internal and external programs to provide training for staff who work with children with special health care needs. The program educates providers, conducts data analysis to define the incidence and prevalence of genetic conditions in the state, and identifies ways to improve the programs and services to women, children, and families.

#### **c. Plan for the Coming Year**

In upcoming year the program will review the newborn screening process, identify any concerns and implement intervention as needed. The program will coordinate a Newborn screening update in the northern, central and southern regions of the state: Grenada-North, Jackson-Central and Hattiesburg-South. The update will address procedures of specimen collection, handling, shipping and changes within the program. In continued efforts to enhance health data portability and collaborate with other programs, the Newborn Screening will be a part of implementing a web based case management system, Natus/Neometrics. This system will integrate newborn screen, newborn hearing and birth defects registry data available remotely through secure web access. The Genetic Services program will continue to work closely with the Genetic Advisory Committee on recommending additional screening for disorders/diseases of newborns. Efforts will continue to build relationships with the birthing hospitals and providers by providing resources to increase education and training on metabolic disease management. There will be ongoing monitoring of hospital quality assurance of specimen collection and handling and provide training as needed. A MS newborn screening data report will be completed and shared with the medical community and at appropriate conferences.

### **Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated**

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

<b>Total Births by Occurrence:</b>	<b>38618</b>
<b>Reporting Year:</b>	<b>2013</b>

Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	37778	97.8	0	0	0	
Congenital Hypothyroidism (Classical)	37778	97.8	15	15	15	100.0
Galactosemia (Classical)	37778	97.8	0	0	0	
Sickle Cell Disease	37778	97.8	58	58	58	100.0
Biotinidase Deficiency	37778	97.8	1	1	1	100.0
Congenital Adrenal Hyperplasia	37778	97.8	3	3	3	100.0
Cystic Fibrosis	37778	97.8	5	5	5	100.0
Hemoglobinopathies	37778	97.8	5	5	5	100.0
Other	37778	97.8	8	8	8	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	37778	97.8	2	2	2	100.0

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	63	63.5	64	69	69
Annual Indicator	60.4	60.4	68.7	68.7	68.7
Numerator	442	442	83820	83820	83820
Denominator	732	732	122059	122059	122059
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2014	2015	2016	2017	2018
Annual Performance Objective	69	69	69	69	69

#### **Notes - 2013**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **Notes - 2012**

Note for report of 2012 data: For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The National CSCHN Survey collects data using the SLAITS mechanism. SLAITS is not an ongoing survey, is not conducted at regular intervals and was last administered in 2009/10 (CDC SLAITS website). National performance objectives for this indicator remain the same during time periods between administration of the survey and will be modified for future years based on the timing of the administration of the next CSHCN Survey.

#### **Notes - 2011**

Note for report of 2011 data: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **a. Last Year's Accomplishments**

CMP continued to focus on inclusive parental involvement, more diverse parental involvement, enhanced customer service, quality improvement for staff and transition efforts. MS continued to work to enhance and assure that family participation in program policy activities in the state's CYSHCN Program is achieved. CMP worked closely with the advisory committee referred to as the Statewide Parent/Professional Advisory Committee (SPAC). Efforts were made to better educate involved parents and professionals on the committee with information on HRSA, Title V,

MCHB and AMCHP. To assist in this effort, CMP's budget was modified to include three parents from the advisory committee to participate in AMCHP's 2014 National Conference. Committee members were offered in-services on the roles of these entities as they relate to them and their involvement on the advisory committee. Parental Involvement continues to be stressed, but without an understanding of the aforementioned programs, increased participation and progress is limited. CMP re-introduced AMCHP's Family Delegate and Family Scholar Programs and a Family Delegate was chosen.

Making the best use of MCH resources, in early May 2013 CMP collaborated with the University of Alabama (UAB) to offer free training to CMP staff and parents on the advisory committee through their training grant. The initial plan was to partner with UAB to offer what CMP has tentatively referred to as MCH 101 and make it part of a routine annual in-service. This curriculum is currently being developed to fit the needs of CMP but will assist the staff and parents who serve on the advisory committee to better understand the relationship the program has with MCH, the importance of parental involvement, performance measures and how the measures shape the program's focus. CMP is hopeful that other trainings will follow and the program will eventually be able to provide accredited training opportunities to staff.

To build greater partnerships and enhance available resources, CMP continued to refer to the various resources identified by parents as a special project by SPAC members who were asked to identify community and statewide resources in their area. CMP, in coordination with other partner agencies, utilizes parent email list-serves as a communication tool to notify parents of upcoming trainings and meetings.

To further CMP's efforts to include families in decision making during each clinic visit, CMP administers and evaluates Family Satisfaction Surveys in Blake Clinic, a multidisciplinary clinic. Parents' input from the survey responses have been considered in programmatic policy and procedure changes. In general, parents were satisfied with their services with the exception of wait time. Efforts continue to minimize patients' and their families' wait time in the clinic and improve their overall clinic experience. By all indications, efforts are working as families continue to express satisfaction on the Family Satisfaction Surveys. An analysis of FY 2013 surveys indicated that of the 446 surveys administered, 433 parents expressed satisfaction with the services their child received from CMP in the past 12 months. Those services were inclusive of gap-filling services such as respite, intensive case management, and Blake Transition Clinic services that focus on the patients' specific transition needs. The aforementioned statistics translates into a 97% satisfaction rate that represents a 2% increase from last year. This might be attributed to the increased emphasis on the delivery of good customer service and efforts made to minimize wait time.

CMP is restructuring their current Resource Directory to make it public health district specific. Once revamped, Central Office, county and district staff will be able to access resources pertinent to their respective districts. CMP plans to link that directory with the existing Early Intervention and other state/local directories to make it a more comprehensive database and increase resource referral statewide. This will greatly enhance the care coordination of those we serve. Due to the loss of CMP's internal IT staff person who was working on the project, activity in restructuring the database has slowed, but staff social workers are being made aware of newly identified resources regularly for referral and the agency is in the process of developing a new patient information system that may enhance this effort.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain family participation through the program advisory committee		X		
2. Assist in coordination of CMP Parent Advisory Council	X			

3. Include patient and family subcommittee input in the MCH Block Grant Needs Assessment				X
4. Continue contractual agreements with community based organizations that serve CSHCN to provide support services for families				X
5. Utilize a Family Satisfaction Survey tool to obtain information from families regarding the services they receive				X
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The program re-directed a lot of their attention to the ACA in educating staff, patients and families of the possible changes. A great deal of focus continues to be placed on the ACA, Medicaid's Managed Care implementations, insurance coverage changes and how it impacts the program. In response to anticipated implications of the ACA and Medicaid Managed Care changes, CMP continues to work closely with agency staff to determine a restructuring plan.

To enhance parents' knowledge of and their involvement with MCH, stipends were made available to fund at least three parents to attend the National AMCHP conference in Washington. One parent attended as a Family Delegate. Those who attended gained a greater insight into the program's requirements as they relate to MCH Performance Measures, the parents' role in assisting the program in meeting those requirements, and an opportunity for parents to learn from neighboring states' best practices and their respective advisory committees' related activities. Attendees will follow-up in developing and presenting an overview of their conference experiences to parents at a future Advisory Committee meeting as an MCH education session. Parental interest has increased and the program remains optimistic that with education and involvement, greater input and participation in decision making will be enhanced.

#### **c. Plan for the Coming Year**

A great deal of agency/program resources will be utilized in the coming year considering how patients and families may be best served with Title V funds in observance of MCH 3.0. Greater emphasis will be placed on offering enabling services. Concentration will be placed on building partnerships and better linking internal and external resources. The program will utilize the education and technical assistance offered by the National MCH Workforce Development Center. Education and training will also be provided to assist patients and families to employ self-advocacy.

In response to anticipated implications of the ACA, CMP has worked closely with agency staff to develop a restructuring proposal if the program moves away from direct care services. Still uncertain of the direct impact ACA will have on the program and those served, it is presumed that many of the families CMP serves may be unable to afford the generous premiums/deductibles associated with plans made available via the Healthcare Market Place. In addition, the Craniofacial population to whom CMP currently provides services may be under-served by the stand alone dental plans offered by the Marketplace. Should this prove true, CMP expects to continue some services to families who are unable to afford coverage or who may be under-served by their selected plan. Although there are no current plans to move away from direct care services, should Mississippi's only tertiary care center move in the direction of offering more community-based specialty clinics, CMP will reevaluate the need for existing program community satellite clinics and other services and look for opportunities to enhance enabling/gap-filling services not offered via ACA/Medicaid Managed Care plans. Services include, but are not limited to transition planning, translation, respite reimbursement services, patient and provider education,



limited patient transportation services, the provision of pharmaceutical assistance to patients with Cystic Fibrosis and Hemophilia and those services offered to address the complex dental needs of the Craniofacial population.

To enhance parent involvement and program information, CMP is considering remote access capabilities for parent groups that will share in CMP's Information and Education Sessions and SPAC meetings off site at a local disability related agency. Conference call capabilities have been assigned and speaker phones are in place at both CMP and the Resource Library conference room areas to support callers.

CMP will continue to focus on delivering good customer service and enhance parental involvement. CMP plans to focus more on Limited English Proficient patients (LEP) to better determine their needs, to link them to culturally sensitive resources and, to promote the advisory committee and encourage their participation.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	46.2	47	47.5	48.2	48.2
Annual Indicator	45.0	45.0	36.8	36.8	36.8
Numerator	340	340	43676	43676	43676
Denominator	756	756	118746	118746	118746
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	48.2	48.2	48.2	48.2	48.2

#### Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **Notes - 2012**

Note 2013: For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The National CSCHN Survey collects data using the SLAITS mechanism. SLAITS is not an ongoing survey, is not conducted at regular intervals and was last administered in 2009/10 (CDC SLAITS website). National performance objectives for this indicator remain the same during time periods between administration of the survey and will be modified for future years based on the timing of the administration of the next CSHCN Survey.

#### **Notes - 2011**

2011:

For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **a. Last Year's Accomplishments**

The agency is divided into nine (9) public health districts; each district has a team which consists of a social worker, nurse and clerk to provide support for the program's efforts of care coordination. In those districts where there is not a nurse, the team may consist of two social workers. The staff provides follow up on children from birth to age 21 and serves as the care coordinator to the patient and their family. The team member is responsible for assisting families with community based resources, identifying the patient's medical home, health insurance, and other relevant services. The program utilizes a database to track the health status of CYSHCN from birth to age 21. They are also responsible for submitting monthly reports indicating the number of children provided case management services.

The Children's Medical Program (CMP) assessed medical home status of all enrollees at the time of application processing, transition clinic and during visits at the specialty clinic. For FY2013, 94 percent of the children enrolled in CMP had a medical home and 62.3 percent of children enrolled in CMP had a dental home.

#### **Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess medical home status at all clinic encounters and make referrals as needed				X
2. Collaborate with primary care physician groups to increase the availability of medical homes				X
3. Continue to coordinate with the University Medical Center to provide care coordination				X
4. Utilize district CSHCN Coordinators to assist in care coordination at the community level				X
5. Continue to provide continuing education opportunities for primary care providers on topics related to CSHCN				X
6. Participate in training for primary care providers on the medical home concept of CSHCN (conferences, continuing education activities, etc.)				X
7.				
8.				
9.				
10.				

#### **b. Current Activities**

CMP assesses medical home status of all enrollees at the time of application processing, Transition clinic and during visits to specialty clinics. CMP and the F2FC provide educational training opportunities, develop and disseminate information for families and providers related to medical homes.

CMP collaborates with LIFE to promote the importance of medical homes at transition clinics and conferences. LIFE is a non-profit organization dedicated to enhancing the lives of individuals with significant disabilities in MS. LIFE has provided core independent living services to more than 35,000 individuals with disabilities throughout the state.

Medical home status is assessed by all Care Team members. The importance of having a medical and dental home is discussed during each clinic visit and referrals to primary providers are made as needed. These efforts will also promote ongoing and comprehensive care.

Current FY 2014 statistics indicate that 94 percent of patients report having a medical home and 62 percent report having a dental home. The assessment of this will continue.

#### **c. Plan for the Coming Year**

CMP will continue to partner with the community based organization, LIFE, to implement transition activities, assist the program in enhancing parental involvement and promote wellness and nutrition. CMP will provide limited funds to assist in their newly established fitness center for the disabled, the first of its kind in the state. LIFE has several activities directly related to program efforts. Throughout FY 2014 CMP will continue to support the F2FC's efforts to provide educational training opportunities and develop and disseminate information for families and providers related to medical homes.

CMP will continue to work closely with the F2FC in association with the newly established Mississippi Chapter of Family Voices.

The long-term care coordination database is an application system used by staff to input and retrieve information for care coordination of patients. CMP will continue to utilize the long-term care coordination database to identify families who need education regarding medical homes.

In the past several years, CMP coordinated activities with the University of Southern MS to implement the MS Integrated Community Systems (MICS) Grant. The grant has since ended, but CMP has implemented sustainability efforts to continue their work in line with the medical and dental home promotion. CMP plans to create a physician database and follow up with providers identified from assessments conducted during Blake Clinic visits. Plans are to target these providers and continue to educate them on the medical home concept and garner their support in being a medical home for many CYSHCN. These efforts are ongoing.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	64.8	66.9	68.4	70.2	70.2
Annual Indicator	58.8	58.8	57.4	57.4	57.4
Numerator	436	436	69740	69740	69740
Denominator	742	742	121497	121497	121497
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	70.2	70.2	70.2	70.2	70.2

#### Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### Notes - 2012

Note for report of 2012 data: For 2011-2014, indicator data is from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes. For the 2009-2010 CHSCN survey, there were revisions to the wording, order, number, and content of questions. As a result, there are issues with comparability across survey years.

The National CSCHN Survey collects data using the SLAITS mechanism. SLAITS is not an ongoing survey, is not conducted at regular intervals and was last administered in 2009/10 (CDC SLAITS website). National performance objectives for this indicator remain the same during time periods between administration of the survey and will be modified for future years based on the timing of the administration of the next CSHCN Survey.

#### Notes - 2011

Note for report of 2011 data: For 2011-2014, indicator data is from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. For the 2009-2010 CHSCN survey, there were revisions to the wording, order, number, and content of questions. As a result, there are issues with comparability across survey years.

#### a. Last Year's Accomplishments

According to CMP's internal database, in FY 2013 91% of CMP's active enrollees had some form of health coverage; this is a 2% decrease from the previous fiscal year. This represented 71% with Medicaid, 20% had private insurance and 9.3% were uninsured. The decrease in the overall insured total could be attributed to patients aging out of the program and not qualifying for Medicaid coverage during this pre-ACA/pre-Expanded Medicaid era and were also unable to afford private health insurance. CMP continues to serve as a payer of last resort for needed services. The data that CMP collects are based on CMP enrollees and cannot be generalized about the CYSHCN population in the state.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify insurance status on CMP applications		X		
2. Verify insurance status at all patient encounters and make referrals to other sources		X		
3. Maintain CMP data system to capture pertinent information				X
4. Continue to work with Medicaid insurers and advocacy groups to promote adequate health coverage for CSHCN				X
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

Currently, 91 percent of CMP patients have some form of health coverage. These numbers did not differ much from the previous fiscal year overall. Currently, 73% of CMP patients have Medicaid, which is a 2.3% increase from the previous fiscal year; 17% have private insurance which is a 3% decrease from the previous fiscal year and there was less than a 1% increase in the number of uninsured patients seen. Overall, it is believed that the uninsured number of patients is due, in part, to the economy with increased job loss and group insurance coverage and those patients who transitioned off Medicaid and were not deemed disabled. The program continues to work to locate adequate health coverage resources for those who transition off the

program who are not deemed disabled by SSA and who are unable to afford health coverage. Although the overall insured rate is a minimal decrease from last year's reported statistics, this percentage reflects only two quarters of FY 2014 and due to the program's routine insurance checks and referral to health coverage resources this number is expected to increase.

The CYSHCN Director submitted a proposal to the National MCH Workforce Development Center for technical assistance, which was accepted. The program's objective is to receive technical assistance and guidance to strengthen internal and external stakeholders' to improve care coordination and systems integration. As a result, the internal MSDH Workforce Development team that consists of Maternal Child Health/Health Services agency staff was formed to facilitate the project.

The program's stakeholders' advisory council has been enhanced to include pertinent key stakeholders who may encounter a CYSHCN during their life cycle. The objective is to bring the key stakeholders to the table to learn from and partner within the program's efforts to improve care coordination and better integrate systems. Core stakeholders include the Department of Education; the Division of Medicaid; the Social Security regional office; Early Intervention; the University of MS Medical Center, the state's only tertiary center; parents from the program's parent advisory council; a representative from the state's WIN Job Center; local universities; representatives from health coverage advocacy groups; community/disability advocacy groups; and other community and state agencies.

The internal team has participated in an intensive training at Chapel Hill where valuable TA and tools were provided. The internal group has used a number of these tools with the Stakeholders' Advisory Council to better define the group's strategies for improved systems integration and care coordination. Although the work with this project has been intensive, it has been quite helpful in facilitating discussion, engaging the group in work group exercises and in working towards change.

### **c. Plan for the Coming Year**

CMP assesses insurance needs of all enrollees at the time of application processing and routinely throughout the year. Support services are provided to assist enrollees in resolving any issues preventing them from obtaining adequate coverage. All applications with no identified insurance are referred to the social worker supervisor for review of possible Medicaid/CHIP eligibility. Those applications with possible eligibility are referred to Health Help for Mississippi, which is a non-profit organization that assists needy families with Medicaid and CHIP applications. Applicants are also referred to the federally facilitated Marketplace and local Navigators for assistance in health coverage eligibility and application. With the implementation of a check and balance system in the application and bill tracking processes, CMP continues to realize success in determining those patients who are uninsured or underinsured, thus expanding efforts to assess and refer those families to needed health coverage resources.

In anticipation of changes due to ACA's implementation, CMP is committed to learning about ACA-related resources and navigation services to assist patients in making an informed decision that works best for their health coverage needs. CMP staff will continue to assess health coverage status of all enrollees and assist families in applying for Medicaid and other available benefits. The goal is to increase the percentage of families with health coverage. CMP serves as a payer of last resort for needed services and will continue to work with Health Help for Mississippi to identify those patients and their families who qualify for health coverage through Medicaid, SCHIP, and the recently implemented ACA Healthcare Marketplace. CMP will focus more on collaborations and partnerships with key stakeholders (Medicaid, Department of Mental Health, Rehab Services, Education, etc.) for this population to identify needs, resources, and solutions to issues.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	92	92.5	93	93.5	93.5
Annual Indicator	90.9	90.9	65.4	65.4	65.4
Numerator	676	676	79935	79935	79935
Denominator	744	744	122288	122288	122288
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	93.5	93.5	93.5	93.5	93.5

**Notes - 2013**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2012**

Note for report of 2012 data: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The National CSCHN Survey collects data using the SLAITS mechanism. SLAITS is not an ongoing survey, is not conducted at regular intervals and was last administered in 2009/10 (CDC SLAITS website). National performance objectives for this indicator remain the same during time periods between administration of the survey and will be modified for future years based on the timing of the administration of the next CSHCN Survey.

#### **Notes - 2011**

Note for report of 2011 data: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **a. Last Year's Accomplishments**

Last year CMP's satellite clinic map was revised to reflect changes in outlining areas. There were 104 clinics held at Blake in FY 2013 during which a total of 1,291 (FY12 1,495) patients were scheduled. Of those scheduled, 808 (FY12 930) of them showed. CMP has 12 different satellite locations statewide to further their efforts of providing service and improving access to care. Through those respective sites, there were a total of 57 (FY12 197) separate clinics held throughout the state. There were a total of 461 patients scheduled and 326 showed.

CMP developed a partnership with MS Parent Training and Information Center to offer information and education in CMP's newly implemented Information and Education Sessions. Efforts have begun to strengthen intra-agency partnerships beginning with MSDH's Early Hearing Detection and Intervention (EHDI) program. EHDI staff recently presented at CMP's latest Information & Education Session to promote program activities and services. In an effort to increase patients, parents and caretakers of CYSHCN awareness of community resources, CMP staff recently teamed with the Statewide Parent/Professional Advisory Committee to sponsor the first Resource Fair and IEP Consultation event. A pre-event survey was administered to CMP Blake clinic patients and their families. Respondents were asked to identify topics of concern and gauge their comfort level in navigating through the IEP process. Ninety percent of those surveyed expressed interest in various community resources. As a result, representatives from many of those identified agencies were invited to present program information during the event. Agencies represented included the Social Security Administration, Mississippi Department of Rehab, LIFE, the ARC, USM/IDS Home for Home Program and MICS Project, and Coalition for Citizens with Disabilities. IEP Counselors were also made available to all attendees to offer counseling and address any specific concerns of parents and caretakers of school age CYSHCN.

CMP identified an additional state resource that will be helpful in the program's future efforts to develop a plan to improve patients' and families' access to community resources. The CMP Director contacted the Director of the Office of Deaf and Hard of Hearing (ODHH), a division of the MS Department of Rehabilitation Services. Thus far, they've worked to locate a sign language interpreter and a Spanish interpreter for patients and their families during clinic when our Spanish Interpreter was not available. CMP is optimistic that this agency, which has a large database of interpreters in the state, could be instrumental in sharing disability related resource information with those they serve in efforts to improve Limited English Proficient (LEP) families' access to community resources.

Through association with the Statewide Parent/Professional Advisory Committee CMP has



developed relationships with other agencies the members represent. These agencies are Magnolia Speech School, MS Methodist Rehab Center, and Jackson State University's Metro Jackson Community Prevention Coalition Crisis Prevention Resource Project. In members' dual role as committee member and parent, they've shared disability related news with the committee and ways CMP may join in their efforts to educate parents and families about disability related services. Efforts were enhanced this year to strengthen a long standing relationship with the MS Rehab Center in Tupelo, MS. This facility has provided ongoing medical services, speech therapy and case management to many of the children CMP serves and who reside in North MS. This facility is vital to access to quality specialty care and case management. To ensure continued services to Orthopedic and Cleft Lip and Palate patients and their families in North Mississippi, CMP explored ways to strengthen this relationship. CMP's district staff have increased their role in clinic and now have more involvement in clinic organization and case management follow-up.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide and coordinate community-based CSHCN subspecialty medical clinic sites throughout the state to improve access				X
2. Continue to collaborate with families and providers to ensure continuity of care				X
3. Maintain a collaborative relationship with community health centers to provide other needed services				X
4. Facilitate communication between specialty and primary care providers through care coordination initiatives				X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

There is ongoing evaluation of the satellite clinics to determine need and efficiency. Feedback is sought from providers, patients/families and staff. As specialty providers' resources are limited, it is critical that the satellite clinics are effectively meeting the needs of the population and community. Providers from UMMC, Le Bonheur Children's Hospital and St. Jude's Children's Hospital provided services in regional locations in the state. CMP continues to contract with the MS Chapter of American Academy of Pediatrics to provide respite care for families.

CMP has restructured the existing Parent Advisory Committee to include parents and professionals from state and community organizations, representatives from the University of Southern Mississippi Institute for Disability Studies (IDS), and Living Independence for Everyone (LIFE). This group is now referred to as the Statewide Parent/Professional Advisory Committee. This collaboration will enhance the number of parents reached and linked to community resources by sharing the List Serve of each of the partner agencies. It will also enhance parental involvement and make for a more diverse representation in considering committee activities that will promote statewide change. CMP's Medical Director maintains an informal relationship with providers and professionals who provide specialty services to CYSHCN. This group acts to advise CMP and is relied upon for consultation in considering policy and programmatic changes.

#### **c. Plan for the Coming Year**

CMP continues to contract with LIFE to assist families in navigating the health delivery system. The CMP/Genetics teams continue to provide a link between families and providers at the community level in their continued work with families to assess needs, address barriers and identify local/community based resources. The long-term care coordination database is being used to refer families to resources in the community.

In an effort to make community and statewide resources better known to patients and their families, CMP will continue to restructure Resource Directory. Although efforts to complete this project have been hampered by recent staff changes, CMP's social service staff will continue to seek out resources pertinent to the patients' and their families' needs and maintain an up-to-date list of those resources for convenient access and quick referral. CMP's parent and professional list-serve databases will continue to be maintained to better inform patients, parents and professionals of statewide and community events and resources. CMP will continue to sponsor their bi-annual Resource Fair to better inform patients and parents of available resources and allow parents an opportunity to meet representatives of disability related resources and pose whatever specific questions they may have.

The Statewide Parent/Professional Advisory Committee will continue to work to complete a project to develop a Resource Book that lists specific and vital resources and tips for parents as relates to certain milestones in the life of a child with a disability. The plan is for this booklet to be provided to new parents of a special needs child to show them the developmental milestones of a disabled child, listing statewide and community resources helpful during each stage.

Throughout FY 2014, CMP's F2F Parent Consultant will continue to provide additional education resources on medical home and CYSHCN resources around the state. The long-term care coordination database will be utilized to identify community based resources utilized by families. Parent and provider surveys will continue to be utilized to assess gaps in services.

Emphasis will be placed on our limited English proficient (LEP) patients and their specific resource needs. CMP will join with their contract interpreter to survey these families in an effort to determine their needs, how they're currently being met, their opinion as to how CMP may assist them and how the program may lead them to parental participation on the advisory committee. It remains CMP's goal to have a diverse advisory committee inclusive of and representative of those we serve.

CMP's unique location in the Jackson Medical Mall which is situated in an economically impoverished community served by public transportation is aligned with other medical offices, clinics and other agencies that serve the disabled population. This location makes access to community based resources easy for patients and their families to use.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	32.5	34	35.8	37.5	37.5
Annual Indicator	30.9	30.9	38.5	38.5	38.5
Numerator	104	104	17416	17416	17416
Denominator	337	337	45208	45208	45208
Data Source	National CSHCN	National CSHCN	National CSHCN	National CSHCN	National CSHCN

	Survey	Survey	Survey	Survey	Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	37.5	37.5	37.5	37.5	37.5

### Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

### Notes - 2012

Note for report of 2012 data: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The National CSCHN Survey collects data using the SLAITS mechanism. SLAITS is not an ongoing survey, is not conducted at regular intervals and was last administered in 2009/10 (CDC SLAITS website). National performance objectives for this indicator remain the same during time periods between administration of the survey and will be modified for future years based on the timing of the administration of the next CSHCN Survey.

### Notes - 2011

Note for report of 2011 data: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three

surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **a. Last Year's Accomplishments**

To better assess the patients' needs and to link to other providers and resources, CMP revised a number of assessment tools and implemented a new Nurses Assessment Tool. Information about the patient's medical home and school health providers will be used to develop relationships with those providers and better prepare the patient for transition. By the close of FY2013 staff realized the usefulness of this tool that has worked well as an interview guide and for tracking/obtaining needed information for future transition planning.

Individual one-on-one consultations by the multi-discipline team in clinic was helpful in further assessing the patients' needs. District Genetic/CMP Coordinators shared in this effort through their case management follow-up activities at the local level.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner with agencies and organizations working with adolescents on transition issues		X		
2. Enhance the transition clinic for the transition of CSHCN to adulthood		X		
3. Ensure that transition services are discussed with patients at appropriate age levels		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

CMP staff and regional nurses, nutritionists and social workers, along with other specialty team members, provide multi-disciplinary services in Blake and satellite locations. Emphasis is placed on services necessary to transition enrollees to adulthood. Examples include community life, employment and independent living skills, and individual education plan-support activities.

As a component of services, CMP social workers assess the patient's transition status and needs during each clinic visit. To further ensure that each CMP patient is adequately prepared to transition from CMP services to adult health care, CMP schedules monthly special transition clinics in Blake Clinic to provide specific transition case management to those patients who would soon age out of the program.

Although CMP had begun discussions with the Social Security Administration (SSA) to request a designated representative to attend the Transition Clinic held at Blake, the logistics of this have not been worked out. Efforts will continue to implement this SSA liaison in transition clinic. A similar arrangement has been implemented with the MS Department of Education and is working well. It is anticipated that this resource will prove to be valuable for patients and families in their transitioning process.

### c. Plan for the Coming Year

Mississippi will continue to enhance their focus on transition. Transition clinics will continue to be strategically scheduled separate from a routine clinic visit so as not to exhaust the patients by combining it with a routine clinic visit or to interfere with the coordinated care visit. Although the show rate is low, fewer patients are scheduled to allow for a more comprehensive multi-disciplinary assessment. For some patients, transition may begin at age 14 which may contribute to the low show rate in clinics. Since patients are routinely scheduled for transition clinic up to their 21st birthday, some patients may occasionally elect to forego a clinic visit because there will be other opportunities to attend. During these visits a routine assessment is done to determine their transition needs and address any urgent transition issues. The impact of Medicaid's Managed care and patients' use of assigned primary health care providers and the increase in fuel costs further increases the likelihood that families will choose a specialty medical clinic visit over an isolated transition clinic visit. For those patients who show, CMP and Living Independence for Everyone of Mississippi (LIFE) will continue to provide targeted transition services to children and families on topics such as health care reform, self-advocacy, transition to community life, peer support, skills support, advocacy, waiver services, information, and occasional referrals to vocational rehabilitation services. To better identify available resources, offer a seamless system of care coordination and improve work relationships with internal and external stakeholders, CMP will continue efforts to strengthen partnerships with identified stakeholders and concentrate on systems and infrastructure building. CMP will implement information learned from the education and technical assistance provided through the National MCH Workforce Development Center to achieve this goal.

CMP will continue to partner with LIFE to provide necessary training and support to transition children and youth to adult healthcare settings. During the remainder of FY 2014 the F2FC will continue to collaborate with CMP to provide training resources and facilitate community participation for CYSHCN transitioning to all aspects of adult life. CMP will continue to explore the addition and enhancement of transition clinics and services to other regional sites around the state.

CMP will continue to work closely with the advisory committee and review other states' best practices to determine ways to enhance Transition Clinic show rates. Parents on the advisory committee, patients, and staff will continue to hear the message that "transition starts now" and will be relied upon to assist the program in locating resources helpful in making transition a smooth process for those CMP serves.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	90.5	91	91	91	91
Annual Indicator	82.3	83.0	77.0	83.3	83.3
Numerator	858	835	781	1243	1243
Denominator	1042	1006	1014	1493	1493

Data Source	MSDH - Communicable Disease	MSDH - Communicable Disease	MSDH - Communicable Disease	MSDH - Communicable Disease	MSDH - Communicable Disease
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	91	91	91	91	91

#### Notes - 2013

Field Note: The methodology that was used to calculate this data in previous years is no longer available.

2013: Mississippi immunization rate (4:3:1:3:3) for children 19-35 months of age is 79.3%. The data is retrieved from the National Immunization Survey (NIS). The NIS is sponsored by the Centers for Disease Control and Prevention (CDC). The study collects data by interviewing households in all 50 States, the District of Columbia, and selected large urban areas. The interviews are conducted by telephone with households selected by random chance. The target population for the NIS is children between the ages of 19 and 35 months living in the United States at the time of the interview. Data from the NIS are used to produce timely estimates of vaccination coverage rates for all childhood vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP).

#### a. Last Year's Accomplishments

The Mississippi State Department of Health (MSDH) Immunization Program continues to promote vaccines as one of the most cost-effective clinical preventative services. Continuous provider focused and community focused educational initiatives promote vaccines as a method of reducing illness, hospitalization, and death from vaccine preventable diseases and other infectious diseases.

The MSDH Immunization Registry, Mississippi Immunization Information eXchange (MIIX), is a statewide system that records immunizations administered by both public and private healthcare professionals practicing in MS. The registry is a real-time system, which also provides access to patient immunization records; consolidates patient immunization histories, generates parental reminder notices when immunizations are due, overdue, or invalid; and is critical to supporting Mississippi's efforts to maintain vaccine coverage rates. In addition, parents, legal guardians, physicians, daycare operators, and school nurses request and receive official Immunization Certificate of Compliance forms (Form 121) through requests made to registry staff. MS healthcare providers continue to use MIIX as a valuable tool for clinical decision support, identifying any unmet immunization needs.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue vaccine distribution and administration			X	
2. Monitor immunization levels of the state's children				X
3. Administer the Vaccines for Children (VFC) program			X	
4. Provide disease surveillance and outbreak control			X	
5. Inform and educate the public about the importance of immunizations			X	
6. Enforce the state's immunization laws			X	
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The MSDH Immunization Program operates a robust Vaccine for Children (VFC) Program. In 2013, MSDH staff conducted 522 site visits to 467 enrolled VFC Providers, providing education, monitoring compliance with program requirements, and assessing provider vaccine coverage rates. Forty-nine percent, or 21 of the state's 44 birthing hospitals, are VFC providers.

In 2013, the Immunization Program Staff provided clinical decision support, information, and in-service education to nursing field staff. Staff also provided the same services to health care providers, community based organizations (CBOs), and the general public.

Prevention and Public Health Funding (PPHF) was used to enhance program operations in the following areas: Vaccine Storage and Handling, 2D Barcode scanning of vaccine vials and related products, and Interoperability. Through these funding opportunities, the use of the Vaccine Storage and Handling Toolkit, a comprehensive resource for providers on vaccine storage and handling recommendations and best practice strategies, was disseminated and promoted, enhancements were made to MIXX to begin implementation support to scan 2D Barcoding on vaccines, and staff worked with providers to support the achievement of Meaningful Use, Stages 1 & 2.

#### **c. Plan for the Coming Year**

The Immunization Program will continue to educate Mississippians by means of brochures and informational packets distributed through local health departments for use during health fairs and as handouts. These educational materials will also be provided to VFC providers to distribute to parents of patients.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	31.8	30.5	30.1	29.7	29.7
Annual Indicator	39.5	30.7	30.7	22.1	22.1
Numerator	2552	1965	1965	1349	1349
Denominator	64611	64029	64029	60921	60921
Data Source	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	29.7	29.7	29.7	29.7	29.7

**Notes - 2013**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**Notes - 2012**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**a. Last Year's Accomplishments**

In CY 2013, over 55,476 low income uninsured men, women, and teens across our state received high-quality education, contraception, counseling, and preventive health screenings. In addition to clinical services, the program focused on community education, outreach, and family involvement. These efforts occurred at the state and local levels to promote family planning services as part of an overall health promotion and disease prevention strategy. Evidence-based health education services were provided to adolescents and adults on a variety of topics including contraception, sexually transmitted infections, and healthy relationships.

The MSDH Comprehensive Reproductive Health (Title X) program maintains the State Advisory Council Meeting. Each of MSDH's nine public health districts has a family planning advisory committee which is comprised of five to nine members that are broadly representative of the community. The Advisory Committee functions to promote the awareness and opportunities of family planning services in the community, partner in accomplishing the Title X Family Planning Program community outreach efforts, assist in public education/awareness efforts, and provide suggestions for improving access to family planning services.



Special Initiatives Contracts between MSDH, Title X Comprehensive Reproductive Health, and Jackson Hinds Comprehensive Health Center(s) and Northeast Mississippi Sexually Transmitted Infection Project were implemented to provide services that are not covered under the Family Planning Project. The project provided testing and treatment for both Gonorrhea and Chlamydia infection in females 15-26 in an effort to reduce prevalence rates in target population.

MSDH Comprehensive Reproductive Health participated in the Mississippi Baptist Convention, a statewide organization of Baptist churches which seeks to promote mission, education and church support. First organized in 1824, it holds its annual meeting in Jackson each November. Affiliated institutions include Blue Mountain College, Mississippi College, William Carey College and the Mississippi State Department of Health. MSDH Comprehensive Reproductive Health provided information on Health Services, Teenage Pregnancy, STI and other reproductive health services to over 1800 adults and youth.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support Statewide Abstinence Education Program				X
2. Meet with ministers and church organizations to solicit help in addressing teen pregnancy				X
3. Increase collaboration between adolescent pregnancy prevention programs that focus on minorities				X
4. Collaborate with community health centers in all medically underserved counties				X
5. Counsel teens regarding availability of family planning services during postpartum home visits		X		
6. Work with school nurses on counseling teens regarding risky behaviors and goal setting		X		
7. Counsel children ages 9-18 regarding postponing sex, discussions related to reproductive health and contraception		X		
8. Develop partnerships between Mississippi OB/GYN medical consultants and other providers				X
9.				
10.				

#### **b. Current Activities**

The MSDH Comprehensive Reproductive Health program continues in its mission to prevent unintended pregnancies to teens throughout the state of Mississippi. Title X program staff will continue to work to see a decrease in unintended pregnancies by participating in statewide events as well as serve as experts by providing information, educational materials, and program assistance during both community and educational events that are currently scheduled. At each event the Comprehensive Reproductive Health Program discusses various teen issues including sexual coercion, sexual myths, contraceptive options, abstinence, sexually transmitted diseases, HIV/AIDS, risky teen behaviors and teen pregnancy.

The Family Planning program also provides preconception care to non-pregnant women of childbearing age and meets with educators, ministers and church organizations to solicit help in addressing teen pregnancy.

The Adolescent Health Program works to cultivate partnerships with major community leaders to reduce pregnancies among adolescents aged 15 through 19 years.

#### **c. Plan for the Coming Year**

The Comprehensive Reproductive Health Program will continue contracts with delegates across the state to provide counseling, education, interventions, and free contraception to target adolescents/teens. The activities of these delegates will continue to encourage and promote teen pregnancy awareness. Educational materials are used for counseling and reinforcement of the importance of behavior modification regarding abstinence, drug use, STDs/HIV, reproductive health care, human trafficking, and contraception to reduce the incidence of teenage pregnancy. Comprehensive Reproductive Health staff will continue to provide factual information on teen pregnancy.

The MSDH and MDHS will continue to jointly lead Governor Phil Bryant's Healthy Teens for A Better Mississippi Teen Pregnancy Prevention Taskforce (HTBM) and work to implement strategies to reduce teenage pregnancy by 2017. The MSDH and MDHS have applied for a Pregnancy Assistance Grant to assist expecting and parenting teens to achieve reproductive life planning, educational and career goals. The cross-section of MSDH staff will continue to participate on HTBM subcommittees with community stakeholders. The Adolescent Health Coordinator will maintain work with the Governor's Office on the HTBM Initiative.

The MSDH will continue the new and innovative informational booths at the State Baptist Convention and other venues along with other services statewide.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	30	30	30	30	30
Annual Indicator	23.5	23.5	23.5	23.5	23.5
Numerator	453	453	453	453	453
Denominator	1928	1928	1928	1928	1928
Data Source	MSDH/National Oral Health Surveys	MSDH/National Oral Health Surveys	MSDH/National Oral Health Surveys	MSDH/National Oral Health Surveys	MSDH/National Oral Health Surveys
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	30	30	30	30	30

#### **Notes - 2013**

Note for report of 2012 data: The most recent school year information is 2010 - 2011. Population data form 2011 - 2012 school year is not yet available. For the 2010-2011 school year, 23.5% would equal 8,967 sealants among 38,156 third grade students.

Figures are reported from the National Oral Health Surveillance System (NOHSS). The NOHSS state oral health survey is conducted every five years; the most recent survey was performed during the 2009-2010 school year. Forty-five schools were selected from all public elementary schools with one or more students in third grade. Dental hygienists completed the screenings using diagnostic criteria comparable to ASTDD's 1999 Basic Screening Survey. Of the 3,483 eligible students, 1,928 were screened; for a response rate of 55%. Estimates presented are adjusted for non-response.

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#### **a. Last Year's Accomplishments**

MS Seals, the school-based preventive service program continues to make progress in delivering dental sealants and fluoride varnish to children in need of preventive dental care. Dental teams in private practice and community health centers assisted in increasing the number of children receiving dental sealants. The number of children screened increased slightly this year: 1,507 children received a dental screening and 1,085 children received dental sealants resulting in 7,836 tooth surfaces were sealed.

The Make a Child Smile program continues to experience an increase in participation. More than 14,900 children participated in this state fluoride varnish program, which is close to a 32 percent increase in participation. Program participants included 11,998 children in Head Start programs and 3,007 children in other child care programs.

The oral health program continues to provide early childhood caries training for physicians and nurse practitioners through support from the DentaQuest Foundation. These trainings are an effort to increase the number of medical providers screening children from 0-3 years old.

Tobacco control promotion also continued during this year. The SOHP partners with the Office of Tobacco Control to promote tobacco cessation activities and awareness of risks from primary and second-hand smoke exposure for Head Start grantees, staff, and families. In child care centers, 127 Tobacco Control events occurred with 522 participants. In addition, SOHP regional consultants held 3,721 education/training events that included a total of 22,867 participants.

As a part of the DentaQuest Foundation program, the Office of Oral Health is working with the MS Oral Health Community Alliance to develop oral health literacy initiatives in the eight regional chapters of the alliance. Members of the alliance collectively agreed upon focusing on improving awareness of oral health issues through improving literacy.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement state oral health plan and measure progress to achieve objectives				X
2. Support and sustain statewide oral health coalition activities				X
3. Expand school-based dental sealant program at eligible public schools			X	
4. Increase number of fluoride varnish programs at Head Start centers			X	
5. Expand proportion of population receiving community water fluoridation			X	
6. Develop oral health surveillance plan and burden of disease report		X		
7. Increase and enhance oral health education and promotion activities		X		
8. Expand community safety net dental care outreach via mobile dental clinic (TDOT)	X			
9.				
10.				

#### **b. Current Activities**

The MS Oral Health Program is one of 22 recipients of the CDC Cooperative Agreement on State Oral Health Prevention Programs. With these funds the program is developing capacity and building support for program efforts through hiring additional staff that include an epidemiologist, a sealant program coordinator and a program manager. These funds allow for the expansion of the preventive services and health promotion activities already established.

### c. Plan for the Coming Year

The resources to provide preventive interventions and health promotion activities are sought to continue program efforts. Plans to develop an oral health surveillance plan to assist in providing the evidence for the need to support oral health program efforts will be in development.

Regional Oral Health Consultants will continue to provide preventive services including dental sealants in elementary school-aged children and fluoride varnish in Head Start programs. Since these services are rendered in conjunction with the program's partners, these relationships will continue in an effort to improve oral health for the most vulnerable populations in the state.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	7.2	6.8	6.5	5.5	5.3
Annual Indicator	6.9	4.2	7.2	6.8	6.8
Numerator	44	26	45	42	42
Denominator	634548	624548	623581	621204	621204
Data Source	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	5.1	4.9	4.7	4.7	4.7

#### Notes - 2013

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

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Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

### a. Last Year's Accomplishments

Data from MSDH Vital Statistics indicated that injury-related fatalities were a leading cause of death for children ages 1 to 18 years and for infants. Motor vehicle crashes continue to account for most injury-related deaths, typically due to misuse or non-use of child occupant restraints and

seat belt systems. The MSDH Division of Injury and Violence Prevention has continued to target motor vehicle safety and promote correct child occupant protection.

The MSDH Division of Injury and Violence Prevention conducted 70 culturally competent, publicized child safety seat checkpoints at local health departments, community events, shopping centers, pre-schools, and health/safety fairs to promote correct usage statewide. Health Educators and staff from Mississippi Safe Kids (an injury prevention coalition) advertised the checkpoints by sending out flyers, email list serves, and advertised through the local health departments.

We have established a partnership with Blair E. Batson Children's hospital and have contracted with the hospital to continue services with Mississippi Safe Kids. The partnership has expanded our effort of child passenger safety by providing education to staff and expecting mothers as well as new mothers. We have branded in the facility as well, as we have posters, fact sheets, and guidelines relating to child passenger safety. The same has been done on the neonatal unit of the University of Mississippi Medical Center.

Best practices in Child Passenger Safety educational trainings were held in the following locations: Batesville, DeSoto, Hattiesburg, Jackson, Madison, Pearl, Tupelo, Yazoo, and two in Biloxi.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Safe Kids of Mississippi Coalition to initiate legislation				X
2. Partner with local health departments to provide child safety seats to residents of Mississippi				X
3. Develop and implement an initiative to educate and provide information to parents on the proper use of child safety seats		X		
4. Utilize educational videos and informational TIPP sheets		X		
5. Maintain MSDH participation with the Mississippi Association of Highway Safety Coalition				X
6. Work with school nurses and other school personnel to promote safety education related to MVC				X
7. Identify opportunities for collaboration to enhance safety awareness efforts and interventions				X
8.				
9.				
10.				

#### **b. Current Activities**

The Child Occupant Protection Program educates parents, families, and communities about best practices in child passenger safety by training certified Child Passenger Safety Technicians across the state, creating installation stations in all MSDH public health districts, conducting child passenger safety related events, and distributing child restraints to families in financial need.

The MSDH has several preventive health activities aimed at reducing the rate of death and injury due to motor vehicle crashes through many collaborative efforts and promotions. Some of the activities, programs, and/or other means targeted at reduction of Motor Vehicle Crash are:

1. Significant collaboration with the Mississippi Safe Kids Coalition
2. Child Safety Seat distribution program
3. Implementation of programs to provide information to parents regarding proper use of child

restraints

4. Certification of Child Passenger Safety Technicians throughout the state
5. Establishment of inspection stations statewide, where persons responsible for transporting children can have their safety seat checked for proper installation
6. Established partnerships with fire departments and continued efforts to expand our collaborations to law enforcement officers.

### c. Plan for the Coming Year

The MSDH Division of Injury and Violence Prevention will continue to work with different agencies and community based organizations to develop initiatives to reduce MVC rates for the targeted age group less than 15 years of age. The division will also expand collaboration with other agencies, including local police and fire departments, schools, churches, hospitals, and other organizations concerned with the health and safety of children.

The MSDH Adolescent Health Program staff will continue to build partnerships with major stakeholders and community leaders. In order to build those partnerships, the Program will conduct a system capacity assessment, with guidance from the State Adolescent Health Coordinator Resource Center at the University of Minnesota. Internal and external partners engaged through the assessment will serve to expand and refine all programmatic activities.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	18.6	18.9	17.4	19	19
Annual Indicator	16.0	15.4	18.6	18.6	18.6
Numerator	6331	5930	6706	6706	6706
Denominator	39672	38535	35977	35977	35977
Data Source	MS PRAMS	MS PRAMS	MS PRAMS	MS PRAMS	MS PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	2015	2016	2017	2018
Annual Performance Objective	19	19	19	19	19

### Notes - 2013

Note for report of 2013 data: The most recent data available is from 2010 births. Data source is the Mississippi PRAMS 2010 survey; figures represent the percent of mothers who indicated that breastmilk was at least one of the types of food their infant was fed at six months of age. Data shown are weighted counts that represent the population estimate for the indicator.

### Notes - 2012

Note for report of 2012 data: The most recent data available is from 2010 births. Data source is the Mississippi PRAMS 2010 survey; figures represent the percent of mothers who indicated that

breastmilk was at least one of the types of food their infant was fed at six months of age. Data shown are weighted counts that represent the population estimate for the indicator.

#### **Notes - 2011**

Note for report of 2011 data: Data source is the Mississippi PRAMS 2010 survey; figures represent the percent of mothers who indicated that breastmilk was at least one of the types of food their infant was fed at six months of age. Data shown are weighted counts that represent the population estimate for the indicator.

#### **a. Last Year's Accomplishments**

Mississippi WIC provided outreach, training, and support to all delivering hospitals across the state. This training revolves around the Baby Friendly Hospital Initiative. The Baby-Friendly Hospital Initiative (BFHI) is a global program sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding. The BFHI promotes, protects, and supports breastfeeding through The Ten Steps to Successful Breastfeeding for Hospitals, as outlined by UNICEF/WHO.

The Office of WIC continued to work with the MSDH Office of Health Promotion to develop a rating system to recognize Mississippi hospitals that provide mother-baby care that supports breastfeeding (Baby Friendly Ten Steps). New staff are in place within the Office of Health Promotion and efforts are progressing.

The Office of WIC supported efforts to create a human milk bank in our state. Many delivering hospitals order human milk from Texas milk banks if mothers of premature infants cannot pump their own milk. Creation of a human milk bank in Mississippi will keep the spotlight on breast milk as the superior infant food and will normalize its use.

Mississippi Law requires all licensed childcare facilities to provide a place for clients and employees to breastfeed. Childcare facilities must provide at all times:

- A sanitary location (not a bathroom) for nursing or pumping.
- Comfortable seating.
- Access to electrical outlets and running water.
- A refrigerator for milk storage.

The MSDH Office of Childcare Licensure will ensure that childcare facilities are complying with the law. Childcare facilities must also:

- Train their staff in the safe handling and storage of human milk, as specified by the Mississippi Department of Health, Centers for Disease Control, and American Academy of Pediatrics.
- Display breastfeeding materials that positively promote and protect breastfeeding within the facility.

A report from the National Resource Center for Health and Safety In Child Care and Early Education titled National Assessment of Obesity Prevention Terminology in Child Care Regulations 2010 cites language and regulations to use for best practices, including breastfeeding, and mentions Mississippi as one of the best states in this respect. The report may be accessed at [http://nrckids.org/ASHW/regulations\\_report\\_2010.pdf](http://nrckids.org/ASHW/regulations_report_2010.pdf).

The Mississippi Breastfeeding Law also requires employers to allow staff to express breast milk during any meal period or break period.

The Office of WIC trained staff and implemented MIS. This is the first time in the history of the Mississippi WIC Program that we have an automated clinic system.



**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote MSDH clinics as breastfeeding friendly facilities through official agency policy		X		
2. Continue the nationally recognized peer counselor breastfeeding program throughout the Mississippi State Department of Health		X		
3. Continue the implementation of USDA National Breastfeeding Promotion Campaign		X		
4. Distribute a promotional DVD to assist WIC clients, physicians' clinics and hospitals		X		
5. Provide technical training opportunities for health care staff that provides instruction on breastfeeding promotion				X
6. Conduct outreach activities with worksites targeting childbearing populations				X
7. Increase collaboration among Mississippi State Department of Health programs and private providers				X
8. Continue to partner with the March of Dimes to encourage providers to apply for funding to provide patient education				X
9.				
10.				

**b. Current Activities**

The MSDH WIC program continues its policy of allowing breastfeeding mothers to participate longer than non-breastfeeding mothers and to receive follow-up support through peer counselors.

The peer counselor breastfeeding program is a USDA initiative whereby women who breastfeed and participate(d) in WIC are hired, trained and educated to counsel current WIC participants who breastfeed. Mothers who exclusively breastfeed their infants also receive an enhanced food package and receive breast pumps or other devices to support breastfeeding.

Lactation Consultants are available in some areas of the state to provide specialized assistance for high-risk WIC participants who have breastfeeding challenges, and also serve as breastfeeding resources for MSDH clinic staff, WIC breastfeeding staff, and community health professionals. Three certified lactation consultants (IBCLCs) are currently on WIC staff statewide.

**c. Plan for the Coming Year**

Mississippi's plan for the coming year is to continue implementing initiatives to improve the incidence and duration of breastfeeding among women in Mississippi. We will continue to provide breastfeeding training to hospital staff to improve practices that support breastfeeding. We will continue to improve relationships with hospitals so that breastfeeding referrals are made.

Lactation Specialists will continue to provide specialized breastfeeding support and assistance to WIC participants including home visits, telephone follow-up, and issuing breastfeeding devices as needed. Lactation Specialists also make hospital visits when necessary.

We will continue to participate in the Life course workgroup, the infant mortality reduction workgroup, and the Mississippi Obesity Council so that breastfeeding is included as an important precursor to good health.

MSDH will continue to promote public health activities related to breastfeeding education through the use of coalitions, summits, and public health district meetings throughout the state of

Mississippi.

MSDH will continue to provide a supportive environment to enable breastfeeding employees to express their milk during work hours. This includes an agency-wide lactation support program administered by MSDH WIC. MSDH subscribes to the worksite support policy described below. This policy is communicated to all current employees, included in new employee orientation training and the Family and Medical Leave Act (FMLA). Highlights of the MSDH policy are as follows: Breastfeeding employees who choose to continue providing their milk for their infants after returning to work shall receive milk expression breaks, a place to express milk, breastfeeding education, and staff support.

The WIC Program will continue to work hard at increasing the breastfeeding initiation and duration rates by collaborating with delivering hospitals across the states. We will also continue to present breastfeeding training opportunities for hospitals and health department staff.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	99.8	99	99.1	99.2	99.3
Annual Indicator	98.9	98.2	98.2	98.9	98.5
Numerator	41500	38479	39126	37147	37080
Denominator	41964	39172	39825	37569	37644
Data Source	MSDH	MSDH - Early Intervention	MSDH - Early Intervention	MSDH - Early Intervention	MSDH - Early Intervention
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	99.4	99.5	99.5	99.5	99.5

**a. Last Year's Accomplishments**

One of EHDl's goals is to screen all newborns; hearing within 30 days of birth. Final data for 2012 shows that 98.9 percent of newborns were screened for hearing before hospital discharge. The percentage of newborns that received a hearing screening prior to hospital discharge increased from 98.7 percent in 2011 to 98.9 percent in 2012. Non-screened newborns were documented as deceased, home births, parents declined screening, newborns residing in the Neonatal Intensive Care Unit (NICU) for an extended period of time, and newborns that are transferred to another

facility without a documented screening. Annually, EHDI visits and trains staff at birthing facilities statewide on the importance of screening and reporting procedures for tracking and surveillance purposes.

The EHDI Program completed and submit a survey to the Centers for Disease Control and Prevention (CDC) as a requirement of its federal grant. EHDI's 2012 data shows that the program identified 76 infants/toddlers with hearing loss. EHDI referred 100% of children identified with hearing loss to the Early Intervention Program for services. According to the EIP's Registry, approximately 58 (76%) of the children were enrolled in the EIP and are receiving services. Documentation in the EIP's Registry revealed that the other 24% of children were not enrolled due to reasons such as the Service Coordinators' inability to contact families; families were non-responsive to attempted contacts; families declined services; the families moved out of state; or the child died. The EHDI Program continues to collaborate with the EIP staff regarding families of children with hearing loss.

In an effort to obtain additional and accurate contact information for families, the EHDI staff gained access to MSDH's Immunizations Registry and Medicaid's Envision Database. Access to these systems allows the EHDI staff to obtain contact information for families that could have been potentially lost to follow-up. EHDI staff also has access to MSDH's Patient Information Management System (PIMS) to assist with locating families of children with potential hearing loss.

To increase awareness of the EHDI process at the state and local level and to potentially reduce the number of newborns lost to follow-up after failure to pass the newborn hearing screening, a statewide training was conducted in February 2013. The purpose of the training was to update the audience of the goals of the EHDI program and to provide information on enhancement opportunities regarding early hearing screening, diagnosis, and intervention systems for infants/young children and their families. Approximately 150 participants attended the training including hospital nursery staff, audiologists, speech pathologists, early interventionists, Maternal Child Health nurses and social workers, childcare providers, parents, and students. As a result of the training, EHDI has developed additional partnerships among providers working with young children and families to enhance follow-up and improve systems of care for families of children with potential and diagnosed hearing loss.

EHDI is collaborating with the MS Health Information Network (MS-HIN) regarding electronic transmission of data (via secure email) from hospitals to the EHDI program. EHDI began piloting this project with two hospitals in January 2013. As of February 2014, an additional nine hospitals have begun submitting data electronically to the EHDI Program. Twenty-five other hospitals have registered with MS-HIN to electronically send data to the EHDI Program. EHDI's Data Manager has begun visiting hospitals to assist newborn nursery staff with this new process.

EHDI purchased new hearing screeners, ALGO5, portable hearing screeners, and diagnostic equipment to assist hospitals and diagnostic clinics with updating their equipment to a more efficient protocol. Hospitals contact the EHDI Program when their hearing screening equipment is inoperable. The portable hearing screeners will be housed in EHDI Central Office and will be loaned to hospitals upon request to conduct hearing screenings and report the data to the EHDI Program until the hospital equipment is fixed or replaced.

The MS Delta has a lack of pediatric audiologists to diagnose children with hearing loss. The EHDI Program is attempting to identify an audiological provider in the Delta area to conduct diagnostic evaluations on children who fail the newborn hearing screening.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provides technical support to hospitals in regard to the hearing			X	

screening process and upgrading equipment				
2. Provides literature to hospitals for dissemination to parents regarding pass/refer status, follow-up recommendations, and parent support				X
3. Receives and reviews written, electronic and faxed reports from birthing hospitals and/or diagnostic facilities – enters data from reports		X		
4. Reviews screening/diagnostic reports of risk factors for developing hearing loss – enters data from reports		X		
5. Refers families of children with risk factors for developing hearing loss to appropriate resources		X		
6. Monitors reports from diagnostic centers for confirmation of hearing loss		X		
7. Refers families of children with hearing losses to EI and/or other appropriate resources		X		
8. Provides support to families with children identified with a hearing loss in their natural environment (home, daycare, community)		X		
9. Coordinates an advisory committee that offers recommendations for the program				X
10. Collaborates with internal programs, state agencies, private organizations and primary care providers that serve families and children		X		

#### **b. Current Activities**

The EHDI Program will begin to use the new Neometrics Database as its primary surveillance system to track newborn hearing screenings and audiological diagnostic evaluation results. This system will allow the state to share database with the Newborn Screening and Birth Defects Registry.

EHDI contracts with a Parent Consultant (PC) during this project period. The PC has a child with a hearing loss and serves as a "parent to parent" support system to families of children with hearing loss. This individual initiated a start-up chapter of the National Hands & Voices Organization in the state of MS to enhance MS's "Peer to Peer" family support system. The PC has informed EHDI that six members have joined the chapter and two board members have been appointed. In March 2014, the PC will submit a final application to the National Chapter for MS to be approved as an authorized chapter. The PC collaborates and coordinates monthly meetings/conference calls with the National Hands & Voices Organization, providers, and parents regarding policies, procedures, and the status of MS becoming an "official" chapter. The PC has held several meetings across the state with families of children with hearing loss and providers to promote the chapter and enhance advocacy regarding deafness.

The EHDI staff will have its annual conference at Eagle Ridge Conference Center on March 20, 2014. Online registration is available through the MSDH's website.

#### **c. Plan for the Coming Year**

EHDI plans to continue contracting with the Hearing Resource Consultants (HRCs) and the PC to provide consultation to families and providers statewide regarding hearing loss and educational options. The HRCs will continue to contact to obstetricians and gynecologists regarding the importance of sharing newborn hearing screening information with expecting mothers and families. EHDI will continue its collaboration with other MCH programs to educate and increase awareness of newborn hearing screening to families and to potentially reduce loss to follow-up by taking advantage of training opportunities and making recommendations to improve the system of care for families.

EHDI has partnered with the Early Intervention Program regarding updating the EIP's hearing screening protocol. Early Intervention purchased Otoacoustic Emissions (OAEs) Screeners to be able to screen the hearing of children whose families have concerns regarding their hearing, but no diagnosis before the comprehensive multidisciplinary evaluation is conducted. The EHDI and EIP staff are in the process of finalizing a training procedure for the utilization of OAEs before these OAEs can be used in each health district. EHDI's contract audiologist will train EIP evaluation teams on how to appropriately screen hearing of children utilizing the OAEs.

EHDI's Program Staff will continue to register the other birthing hospitals for the electronic transmission of data to the EHDI Program. One of EHDI's goals is to enhance data collection and reporting to the EHDI Program (by electronic transmission of data) from 100% of birthing hospitals by December 2014. EHDI's Program Staff will continue to offer technical assistance to EHDI's internal and external partners regarding any barriers with the tracking and surveillance of the EHDI data.

EHDI will continue to build relationships with other programs to increase awareness of the EHDI system and the importance of follow-up after children fail the newborn hearing screening. The staff will continue efforts to identify a pediatric audiologist in the Delta area to diagnose hearing loss in children. EHDI will plan its 2015 annual training to enhance parents, professionals, and the communities' involvement in the EHDI process. Ongoing community outreach activities are planned to facilitate efforts to reduce loss to follow-up among infants who fail the newborn hearing screening. Educational materials will continue to be disseminated to hospitals, families, and other agencies/programs that serve families of children with hearing loss.

EHDI program staff will continue to meet with the EHDI Advisory Committee quarterly for recommendations for the program. The committee consists of 9 members that include physicians, audiologists, educators, parents, and others as appropriate.

### **Performance Measure 13:** *Percent of children without health insurance.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	11.5	11.1	10.9	10.2	10.2
Annual Indicator	13.4	10.2	9.0	8.9	8.9
Numerator	105377	77234	68902	68040	68040
Denominator	786745	757094	764554	762216	762216
Data Source	U.S. Census Bureau	U.S. Census Bureau	U.S. Census Bureau	U.S. Census Bureau	U.S. Census Bureau
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	10.2	10.2	10.2	10.2	10.2

**Notes - 2013**

Note for report of 2013 data: The most readily available data is from 2012. One year estimates from the 2012 Annual Social and Economic Supplement (CPS ASEC) Survey were used.

**Notes - 2012**

Note for report of 2012 data: One year estimates from the 2012 Annual Social and Economic Supplement (CPS ASEC) Survey were used.

**Notes - 2011**

Note for report of 2011 data: One year estimates from the 2011 Annual Social and Economic Supplement (CPS ASEC) Survey were used.

**a. Last Year's Accomplishments**

The Mississippi Health Advocacy Program (MHAP), a private organization that collaborates with religious groups, social workers, health providers, state agencies (including the Mississippi State Department of Health), advocates, lawmakers and community groups to build a network of support for health system change, began a direct service program to guide parents through the process of securing much needed health care for their children. Health Help for Kids is a program designed to provide health education, assistance, and resources to Mississippi parents attempting to obtain and retain their children's health care benefits. Health Help will also serve as a resource to help Mississippians navigate the new benefits under the federal Affordable Care Act.

MSDH also continued to work with Medicaid to house out-stationed eligibility workers in local health departments in an effort to increase Medicaid and SCHIP enrollment and recertification. Out-stationed workers are state employees at locations other than eligibility offices to process children's Medicaid/CHIP applications.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with Medicaid to address issues and barriers to applying for and receiving Medicaid and SCHIP				X
2. Facilitate dialogue with stakeholders to work with insurance companies to improve access to health coverage for children		X		
3. Assess health coverage status at every opportunity and provide assistance to families in the completion of applications		X		
4. Continue to support the availability of out-stationed eligibility workers in designated county health department clinics		X		
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

MSDH continues to assess health coverage status at every opportunity and refer families to Medicaid's outstation eligibility sites for enrollment and recertification as indicated. MSDH also partners with entities such as Medicaid, Human Services and community health centers in an effort to increase collaboration to help identify uninsured children and expand the awareness of available health coverage groups.

### c. Plan for the Coming Year

MSDH will continue to work with entities such as Medicaid, Human Services and community health centers in an effort to increase collaboration to help identify uninsured children and expand the awareness of available health coverage groups. This will be done at the state agency level, with advocacy groups, and various volunteer projects throughout the state. As an example, clients who seek social services at the Mississippi Department of Human Services are told by social workers about available health coverage for children.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	31	15	14.5	14	13.5
Annual Indicator	15.1	14.5	35.3	26.4	26.8
Numerator	10414	12520	16281	9743	6573
Denominator	69177	86110	46141	36867	24536
Data Source	MSDH-WIC	MSDH-WIC	MSDH-WIC	MSDH-WIC	MSDH-WIC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	13	13	13	13	13

#### Notes - 2011

Note for report of 2011 data: The current percentage shows a large increase for the performance measure. A review of WIC data revealed contract ITS analyses included duplicates that artificially inflated (even possibly doubled) the measure's denominator in past years. As a result, previous estimates were much lower than the actual prevalence. These errors have been corrected and a standard algorithm will be used for future reports.

### a. Last Year's Accomplishments

MSDH partnered with the Mississippi Department of Human Services (MDHS) in offering the Color Me Healthy program in the state. This program was started in 2008 in our state and is for teachers in the preschool setting. Color Me Healthy targets incorporating food variety and physical activity using all five senses and also offers a component for parent education on nutrition and physical activity. Color Me Healthy toolkits have been purchased for every licensed child care center in Mississippi to receive after completing training which is available throughout the state.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to conduct nutrition education and encourage WIC clients to make appropriate food choices and exercise		X		

2. Continue to customize food packages to reflect Risk Codes		X		
3. Continue to recommend and promote healthy lifestyle changes		X		
4. Continue to implement VENA (Value Enhanced Nutrition Assessment)		X		
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The WIC Program works with the Child Nutrition Program in the Department of Education, the Department of Agriculture, and MSDH Nutrition Services to promote Fruits and Veggies-More Matters at school events, worksite wellness programs and education/health fairs.

MSDH Nutrition Services worked with MSDH Childcare Licensure to update nutrition guidelines in the early childhood setting. Mississippi now requires two fresh fruits and one fresh vegetable be served weekly, limits juice, requires water with all meals, snacks, and the limited use of processed foods. No salt, fried foods, chips, candy, or soft drinks went into the guidelines in 2004. Trainings are being conducted throughout the state to educate childcare providers on the updated guidelines.

The Special Supplemental Nutrition Program for Women, Infants and Children entered into a partnership with the Office of Oral Health which allows Oral Health Regional Consultants to provide oral health education classes for WIC participants as part of the Nutrition Education requirements for the program. The classes educate and inform participants about the importance of good oral health care for women, infants and children.

#### **c. Plan for the Coming Year**

WIC will continue to collaborate with MSDH Nutrition Services, the Department of Education and MDHS in the promotion of fruits and vegetables to its eligible participants, and will continue to offer healthy food choices for the recipients of the WIC Program.

WIC participants have a nutrition education contact every three months, and are actively involved in learning the importance of eating fruits and vegetables, whole grain breads/cereals and low fat dairy products. Exercise is stressed as part of a healthy lifestyle, and all participants are encouraged to limit screen time.

#### **Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

##### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	13.5	13.2	13	12.5	12.5
Annual Indicator	15.6	16.6	15.1	15.1	15.1
Numerator	6445	6583	5629	5629	5629
Denominator	41256	39740	37234	37234	37234
Data Source	MS-PRAMS	MS-PRAMS	MS-PRAMS	MS-PRAMS	MS-PRAMS



Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	12.5	12.5	12.5	12.5	12.5

#### **Notes - 2013**

Note for report of 2013 data: The most readily available data is from 2010. Data from the Mississippi PRAMS 2010 survey were used and figures represent the percent of mothers who indicated that they smoked any amount of cigarettes in the last three months of pregnancy. Data shown are weighted counts that represent the population estimate for the indicator.

#### **Notes - 2012**

Note for report of 2012 data: The most readily available data is from 2010. Data from the Mississippi PRAMS 2010 survey were used and figures represent the percent of mothers who indicated that they smoked any amount of cigarettes in the last three months of pregnancy. Data shown are weighted counts that represent the population estimate for the indicator.

#### **Notes - 2011**

Note for report of 2011 data: Data from the Mississippi PRAMS 2010 survey were used and figures represent the percent of mothers who indicated that they smoked any amount of cigarettes in the last three months of pregnancy. Data shown are weighted counts that represent the population estimate for the indicator.

#### **a. Last Year's Accomplishments**

The MSDH OTC provided funds for and promoted the services of the Mississippi Tobacco Quitline and the ACT Center for Tobacco Treatment, Education, and Research. The Mississippi Tobacco Quitline provides free telephone-based and web-based tobacco treatment to Mississippi residents interested in quitting. Nicotine replacement therapies are available to eligible participants. The Quitline implements a special counseling protocol for women who are pregnant. Several bilingual (Spanish and English speaking) counselors are available, as well. The Quitline operates Monday through Thursday from 7 AM to 9 PM, Friday 7 AM to 7 PM, and Saturday from 9 AM to 5:30 PM. The ACT Center provides face-to-face counseling services available in several locations throughout the state. Eligible participants receive nicotine replacement therapies and prescription medications. The ACT Center also conducts cessation intervention trainings for health care providers statewide: primary healthcare providers, alcohol and drug treatment counselors and mental health providers.

The MSDH OTC continued to provide education and training on the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program among Mississippi Primary Health Care Association clinics. Designated clinicians from each clinic will participate in the SCRIPT training. Baseline data will be collected, and an evaluation tool will be utilized to track program progress. It is the intent of the MSDH OTC to implement this program in all MPHCA clinics serving pregnant women. The training has also been presented to divisions within MSDH Health Services and will be implemented in local health department clinics.

The MSDH Office of Health Data and Research received a March of Dimes community grant to reduce smoking among child-bearing-aged women by integrating SCRIPT training into nursing school curriculums. The NEXT (Nurse Educator eXpert Training) Program is a train-the-trainer event for nursing faculty throughout Mississippi's 32 schools of nursing with the potential to

ultimately reach thousands of women across the state.

The MSDH OTC also partnered with organizations, such as the Mississippi Rural Health Association, Mississippi Nurses Foundation, Mississippi Primary Health Care Association, Mississippi Family Physicians Foundation, and Mississippi Chapter of the American Academy of Pediatrics to incorporate evidence-based strategies (i.e., training providers on 5 A's approach) for treating tobacco dependence in clinics.

Mississippi previously developed a State Infant Mortality Task Force comprised of MSDH, Medicaid, March of Dimes, University of Mississippi Medical Center (UMMC), and American Academy of Pediatrics. This group participated in the Region 4 & 6 Infant Mortality, Preterm Birth, and Prematurity Summit in New Orleans and developed six infant mortality work groups comprised of representatives from various organizations across the state. One of the work groups addressed the need to decrease smoking and second-hand exposure for pregnant women and infants. The State Infant Mortality Task force will continue participation in other bi-regional meetings, continue to increase awareness surrounding SIDS and SUID, and educate physicians and health professionals about strategies to decrease infant deaths, prematurity, and preterm births.

The MSDH OTC continues to work with the MSDH Office of Childcare Licensure and the Office of Oral Health to promote Care for Their Air, a program that provides education about the harmful effects of exposure to secondhand smoke. Training and outreach are provided to child care directors and staff who work closely with parents, children, and babies. Those who participate acquire knowledge, skills, and resources to educate parents and children about the health benefits of becoming smoke-free.

In FY13, the MSDH OTC partnered with the MS Primary Healthcare Association to provide training and technical support to three pilot sites to conduct in-house tobacco dependence treatment programs. The target clinics are GA Carmichael in Canton, MS; Greater Meridian Health Center in Meridian, MS; and Jefferson Comprehensive Health Center in Fayette, MS.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with health care providers and health educators to increase health education related to tobacco use			X	
2. Promote and provide training related to smoking cessation to health care providers for educating pregnant women who are tobacco users			X	
3. Incorporate evidence-based strategies (i.e., training providers on 5 A's approach, tobacco-free policies) for treating tobacco dependence in clinics			X	
4. Promote and provide tobacco cessation services to tobacco users ready to quit tobacco use			X	
5. Provide tobacco cessation services to individuals with disabilities			X	
6. Provide tobacco cessation training to alcohol and drug counselors			X	
7.				
8.				
9.				
10.				

**b. Current Activities**

The MSDH OTC continues to work with partners to implement the SCRIPT training that focuses on tobacco cessation treatment for pregnant women. The Director of the Mississippi Tobacco Quitline has participated in the trainings and provided valuable feedback to the SCRIPTS training facilitators. Mississippi was the first state to begin the implementation of SCRIPT. The SCRIPT training is being piloted with MS Primary Health Care Association (MPHCA) clinics.

A total of 78 Mississippi cities and towns have passed comprehensive smoke-free air ordinances. Previous efforts to pass a statewide smoke-free air law have been unsuccessful. The MSDH OTC will continue to inform Mississippians about the benefits of smoke-free air and the harmful effects of exposure to secondhand smoke.

Regional oral health consultants participate in tobacco control efforts through Care for the Air, an initiative to address secondhand smoke. This program targets child care providers and parents of preschool-aged children to encourage and offer tobacco cessation for individuals who are in contact with preschool-aged children.

### c. Plan for the Coming Year

The MSDH OTC continues to provide funds for and promote the services of the Mississippi Tobacco Quitline and the ACT Center for Tobacco Treatment, Education, and Research.

MSDH will continue to provide funds to organizations to provide tobacco prevention education and promote cessation services. Priorities are to provide more education to pregnant women about the harmful effects of tobacco smoke, increase smoking cessation during pregnancy, reduce exposure to secondhand smoke, and eliminate tobacco disparities.

MSDH OTC has contracted with the University of Southern Mississippi's Institute for Disability Studies to lay the framework for improving access to tobacco cessation services among those with mental health or substance abuse disorders.

The MSDH OTC will continue to work with partners to offer the Smoking Cessation and Reduction in Pregnancy Training (SCRIPT) to focus on tobacco cessation treatment for pregnant women. The MSDH OTC will work with the MS Primary Healthcare Association and MSDH staff to implement the program.

The MSDH OTC will partner with the Mississippi Association of Housing and Redevelopment Officials (MAHRO) and the local Housing and Urban Development (HUD) office to educate residents, property managers and owners about the benefits of smoke-free multi-unit housing.

The MSDH OTC will continue to inform Mississippians about the benefits of smoke-free air and the harmful effects of exposure to secondhand smoke.

### **Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective	6.9	6.4	6.1	6	6
Annual Indicator	8.0	7.6	5.5	4.7	4.7
Numerator	18	17	12	10	10
Denominator	223847	224619	217722	211793	211793
Data Source	MSDH-	MSDH-	MSDH-	MSDH-	MSDH-Vital

	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	6	6	6	6	6

#### **Notes - 2013**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

#### **Notes - 2012**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

#### **a. Last Year's Accomplishments**

The MSDH Office of Child and Adolescent Health provides age-appropriate health education resources and information to middle and high school chapters of SADD. The topics are related to behavioral health, alcohol and drug abuse prevention, safety and injury prevention, and positive youth development. The MSDH Office of Child and Adolescent Health also supported the 2012 Teens On The Move Summit during April in Jackson. In April 2013, the Office of Child and Adolescent Health partnered with the Mississippi Department of Public Safety and DREAM, Inc. to support middle and high school student leaders in organizing the Annual Teens On The Move Summit.

The MSDH Adolescent Health Program Coordinator serves on MDMH's Mississippi Transitional Outreach Program (MTOP) Initiative Task Force. The purpose of the initiative is to develop and expand systems of care to Mississippi's Transition Aged Youth (TAY) with serious emotional disturbances and their families to prepare them for living independently and being engaged in the community.

In 2013, the Office of Child and Adolescent Health collaborated with the Mississippi Department of Mental Health, Mississippi Department of Human Services, Mississippi Department of Education, Mississippi Institutions of Higher Learning, and the Attorney General's Office to create multiple one-day educational trainings focused on addressing alcohol and drug abuse, suicide, bullying prevention, underage smoking and drinking prevention techniques, motor vehicle safety, cyber crimes, transitioning, and exploration of healthy choices among middle and high school students. In an effort to reduce the high school dropout rate, the trainings were held on various community college campuses in Mississippi. Participants from middle and high schools were exposed to post-secondary educational, social, and environmental settings. A targeted number of college-age volunteers were recruited from the selected institutions. Based on Mississippi Department of Mental Health's data, the areas of the state with the highest rates of adolescent health and mental health risk factors were selected as training sites. The target sites included: McComb School District, Picayune School District, Pearl River School District, Wilkerson County School District, and Poplarville School District. The Mental Health Awareness and Screening

Summits were successful health and mental health screening assessment tools.

MSDH also contracts with the Rape Crisis Center statewide and the Coalition Against Sexual Assault (MCASA) to provide educational sessions to children and youth. Sessions focus on prevention of bullying, self-respect, self-esteem, and respecting others. The R.E.S.P.E.C.T. and Bullying programs are conducted with pre-kindergarten and continue through 6th grade. The Choose Respect Curriculum, healthy relationships, and teen dating violence are a series of programs that are used for 7th through 12th graders to address age appropriate evidence based curricula and materials. The R.E.S.P.E.C.T. program is presented over a six week period and the healthy relationship curriculum is a 12 week program. These programs are theory driven with preventive strategies developed addressing the community's needs, identified social norms, behaviors, cultures, and attitudes associated with bullying and violence. The presentations are designed to prevent bullying and violence, improve the knowledge and attitudes that correspond to the origins of these behaviors, build skills for respectful interactions, and empower participants to become change agents focusing on violence prevention and healthy and respectful relationships.

Pre- and post-tests are used to measure knowledge gained during the educational sessions. The Rape Crisis Center staff are trained continuously by supervisors and MCASA to ensure that the content of the programs are competent and sensitive to the communities served. The Rape Crisis Centers have been recognized and receive local community awards for their expertise and knowledge on bullying and violence prevention.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop strategies to utilize school and community resources for health education and assist in bridging communication gaps between adolescents and their families				X
2. Collaborate with the MS Department of Mental Health to explore initiatives for preventing suicide deaths among youths and young adults				X
3. Review PHRM/ISS psychosocial assessment records to screen for high risk youth		X		
4. Provide information on available resources throughout the state from various suicide prevention networks		X		
5. Partner with the MS Department of Public Safety to develop strategies to prevent injury and reduce suicide in middle and high schools				X
6. Continue to identify opportunities for collaboration with stakeholders working to prevent injury and reduce suicide in middle and high schools and colleges				X
7.				
8.				
9.				
10.				

**b. Current Activities**

The MSDH Adolescent Health Program collaborates with the Mississippi Department of Mental Health, Bureau of Alcohol and Drug Abuse, DREAM, Inc. and FTC, Inc. to promote the Mississippi School for Addiction Professionals, a nationally recognized comprehensive training conference held at the Hattiesburg Convention Center in April.

Currently, the MSDH Adolescent Health Program partners with the Mississippi Community

Leaders and Interfaith Partnerships (MCLIP) in collaboration with the Substance Abuse and Mental Health Services Administration and the Mississippi Department of Mental Health, Bureau of Alcohol and Drug Services to bring together representatives of faith-based organizations and the community to develop strategies for providing care and support in the areas of health, mental health and substance abuse. The group works together to address the health and behavioral health needs of the entire family and community.

### c. Plan for the Coming Year

The MSDH Adolescent Health Program, along with the University of Mississippi Medical Center, Mississippi Chapter of the American Academy of Pediatrics, DREAM, Inc., and Youth Leadership Jackson will work to promote youth-friendliness trainings statewide to increase the appropriateness of communications directed at adolescents in Mississippi. The program will help health and behavioral health care providers learn how to effectively communicate with and interview teens through role-play and constructive feedback. Providers learn the importance of body language in all its forms, how to ask useful questions, and what to avoid when interviewing a young person. Participants will increase comfort with asking questions about sensitive areas such as sexuality and sexual activity, mental health in general and depression/suicidality.

The MSDH Office of Child and Adolescent Health will continue its collaboration with key stakeholders of the Mississippi Suicide Prevention Network and with the Mississippi Department of Mental Health to develop strategies to address suicide and safety and injury prevention in the state.

The Mississippi Department of Education and MDMH will continue to conduct bullying/youth suicide in-service trainings on suicide prevention for all newly employed licensed teachers and principals as well as provide on-going self-review and monitoring of suitable suicide prevention material.

The MSDH Adolescent Health Program staff will work to build partnerships with major stakeholders and community leaders to reduce alcohol and substance use among adolescents and young adults. In order to build those partnerships, the Program will conduct a system capacity assessment, with guidance from the State Adolescent Health Coordinator Resource Center at the University of Minnesota. Internal and external partners engaged through the assessment will serve to expand and refine all programmatic activities.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	32.3	68	68.2	68.6	69
Annual Indicator	67.1	69.1	63.3	65.0	65.0
Numerator	650	623	552	520	520
Denominator	969	901	872	800	800
Data Source	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5					

events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	69.3	70.4	70.4	70.4	70.4

#### Notes - 2013

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

#### Notes - 2012

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

#### a. Last Year's Accomplishments

##### Perinatal Regionalization Workgroup Progress

Perinatal Regionalization is a system of care that involves coordination between providers and hospitals to ensure that pregnant women and neonates receive risk-appropriate care. This system involves the designation of hospitals based upon their capacity to provide care for a given level of risk for the mother and infant and organized systems of transportation and consultation between hospitals of varying levels of complexity within a geographic region. Regionalization of perinatal services is an effective strategy for decreasing neonatal and infant mortality and morbidity, with pronounced effects on mortality among very low birth-weight infants (<1,500 grams). The success of such a system depends on identification and appropriate referral of women with high-risk pregnancies, maternal transport when indicated, and stabilization and transport of sick infants to hospitals with higher level services when needed.

MSDH successfully incorporated the American Academy of Pediatrics guidelines for perinatal levels of care into the State Health Plan and assisted through the CoIIN in the development of a hospital assessment system. That evaluation will take place in order to assess the capacity for high risk pregnancy and neonatal management in the state. Following the designation of levels of care, we will identify strategies to reduce very preterm births in non-level III facilities. We are establishing an obstetric workgroup to address maternal health factors.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to work with the Mississippi Perinatal Association, Medicaid, Hospital Association, March of Dimes and other stakeholders to evaluate the regionalization system Mississippi				X
2. Update the current system in accordance with evidence-based standards of care				X
3. Conduct annual hospital surveys to identify quality and quantity of perinatal and neonatal staff expertise, including maternity and newborn		X		
4. Assess facility availability across the state for perinatal practices and statistics for use in state planning		X		

5. Continue to provide financial assistance to the tertiary center for newborn transport		X		
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Currently, calculating the NPM 17 is limited due to the current information available to MSDH regarding hospital capacity according to the new AAP guidelines. A new survey is being designed in collaboration with the Centers for Disease Control & Prevention and HRSA to determine the level of care designation of hospitals based upon the updated American Academy of Pediatrics Guidelines. This assessment is prepared and being piloted in nearby states. Once fully available, we will implement the assessment..

Once Level I and Level II facilities are identified by the updated survey, MSDH intends to more closely evaluate very low birth-weight/preterm births that occur outside of Level III facilities, in order to identify barriers to appropriate maternal transport.

Furthermore, MSDH has begun to follow very low birth-weight/preterm infants that are born to Mississippi mothers in neighboring states that have facilities for high risk neonates. Data reveal that up to 12 percent of very-low birth weight babies born to mothers from Mississippi are born out of state in hospitals that serve border territories. Most of these mothers are appropriately transferred out of state to deliver at an appropriate level facility; however, NPM 17 does not currently capture those births. In order to more accurately understand how high-risk mothers are being managed in Mississippi, it is necessary to follow arranged deliveries that take place out-of-state.

#### **c. Plan for the Coming Year**

As part of the Collaborative Improvement and Innovation Network to Reduce Infant Mortality, MSDH intends to work to improve the number of very low birth-weight or <32 week infants born in Level III facilities by 20 percent by the end of 2015. Progress has been slow over 2014, but once the assessment is complete we anticipate having the data to move forward in making improvements. MSDH has committed to several key strategies to improve this measure including 1) engaging leadership on the local, state and national level, 2) Collecting data to more accurately reflect levels of care in the state, 3) Working with insurers to modify reimbursement policies to encourage appropriate antenatal transport to Level III facilities, 4) Working with March of Dimes to encourage and ensure that hospitals meet the AAP guidelines for neonatal care, 5) Modifying existing CON laws to ensure hospitals meet accepted standards for Level III care and have documented transfer agreements.

Work will continue with the Collaborative Improvement and Innovation Network Perinatal Regionalization workgroup and the MSDH Perinatal Regionalization Advisory group to execute the strategies to increase the number of very low birth-weight/preterm infants born in appropriate level facilities by 20 percent.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
--	-------------	-------------	-------------	-------------	-------------



Annual Performance Objective	88.6	89.5	90.1	83.3	83.3
Annual Indicator	82.8	83.2	84.0	84.7	84.7
Numerator	35445	33249	33459	32706	32706
Denominator	42809	39984	39825	38618	38618
Data Source	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	83.3	83.3	83.3	83.3	83.3

#### Notes - 2013

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

#### Notes - 2012

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

#### a. Last Year's Accomplishments

CDC reports the US has experienced a 12 percent decline in the infant mortality rate from 2005 through 2011. During the first 12 weeks, the growing baby is in a period of both rapid and critical growth and development when all of its major external and internal organs are developing basic structure. The MSDH Office of Women's Health strives to ensure pregnant women have access to prenatal care through counseling, education, and services. Many lack adequate health insurance to cover pregnancy costs and are more likely to delay prenatal care to the 3rd trimester or go without it entirely. MSDH offers a sliding scale fee to uninsured and under-insured individuals to ensure that prenatal care is provided as soon as possible. Prenatal care in the first trimester is key in monitoring the health of both mother and baby. The Office of Women's Health like many other states were depending on the expansion of Medicaid to assist with covering most low income women for prenatal care. However this did not occur.

Mississippi's infant mortality rate is declining. In 2012 the state's infant mortality rate was 8.8 per 1,000 live births, compared to 9.4 in 2011, 9.6 in 2010, 10.0 in 2009, 9.9 in 2008, 10.1 in 2007, 10.5 in 2006 and 11.4 in 2005. Mississippi continues to rank 50th. The MSDH is collaborating with healthcare providers and community leaders across the state focusing on six evidence-based strategies to improve maternal and infant health. Strategies for reducing infant mortality include:

1. Reducing non-medically indicated deliveries before 39 weeks
2. Reducing tobacco use during pregnancy
3. Improving maternal health before and in-between pregnancies

4. Improving safe sleep practices that reduce SIDS and sleep related deaths
5. Reducing recurrent preterm births through use of 17P (17-alpha hydroxyprogesterone caproate) treatment
6. Enhancing perinatal systems of care for high-risk mothers and infants

MSDH partners with the Healthy Teens for a Better Mississippi initiative promoting abstinence-only and abstinence-plus education, youth development, coalition building, and media outreach to achieve healthier infants and decrease teenage births.

In 2012, Mississippi had a reduction in SIDS deaths by 50% (from 42 to 21), teenage births by 8% (from 5,362 to 4,778) and tobacco users in pregnancy by 8% (from 4,410 to 4,045).

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Medicaid and Mississippi Department of Human Services to include information on prenatal care, WIC, and family planning with AFDC checks and Food Stamp mailings	X			
2. Collaborate with Mississippi Food Network to distribute information about prenatal care				X
3. Collaborate with the March of Dimes to develop media materials related to early prenatal care				X
4. Collaborate with the Healthy Baby Campaign, a multi-state campaign to provide coupons for pregnant women who initiate and continue prenatal care				X
5. Collaborate with March of Dimes to implement Stork Nests for clients receiving continuous prenatal care				X
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Medicaid information and/or referrals for Perinatal High Risk Program and Text4baby (educational information through mobile technology) are provided. MSDH ensures pregnant women and mothers with infants have access to Text4baby and essential health education. Since 2/2/2012, Mississippi has enrolled 9,469 pregnant women and mothers in Text4baby. The educational information through mobile technology is an exceptional way to reach more women at an early stage of pregnancy.

The Office of Women's Health also provides tear pads, posters, and brochures to local health departments, WIC Centers, OB/GYN offices, and does community presentations and health fair appearances. MSDH's toll free number is also an asset to helping pregnant women with locating a physician, delivery planning, smoking cessation, breastfeeding, and other pertinent health information.

#### **c. Plan for the Coming Year**

Prenatal care in the first trimester is key in monitoring the health of both mother and baby. The MSDH Office of Women's Health strives to ensure pregnant women have access to prenatal care through counseling, education, and services. The Office of Women's Health assures access to quality comprehensive health care through health department clinics statewide and referral listings. Services include a medical history to identify risk factors, and a family history of

congenital anomalies and genetic diseases; discussion of proper nutrition, prenatal vitamins, exercise, and sexual activity during pregnancy; work; use of illicit drugs; expected due date; and a physical/pelvic exam. Lab tests include RH status, hemoglobin, Sickle Cell, immunity to certain infections (rubella and chickenpox), Hepatitis B, sexually transmitted diseases (syphilis, gonorrhea, chlamydia) and HIV. A urine sample is checked for signs of bladder/kidney infection.

## D. State Performance Measures

**State Performance Measure 1:** *Percent of infants born with birth weight less than 1,500 grams.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective			1.9	1.7	1.5
Annual Indicator		2.1	2.2	2.1	2.1
Numerator		849	872	800	800
Denominator		39984	39825	38618	38618
Data Source		MSDH - Vital Statistics	MSDH - Vital Statistics	MSDH - Vital Statistics	MSDH - Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	1.4	1.1	1.1	1.1	1.1

#### Notes - 2013

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

#### Notes - 2012

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

#### a. Last Year's Accomplishments

The Perinatal High Risk Management/Infant Surveillance System (PHRM/ISS) program focused on ensuring that moms who deliver preterm or small for gestational age infants were enrolled in a family planning program to space the next baby and help to assure a healthy mom prior to becoming pregnant again. The PHRM program provided inter-conception counseling and care coordination for high risk clients. The inter-conception care is started with the two week post partum visit. Folic acid is provided to all clients of reproductive age through the agency's Comprehensive Reproductive Health Program. Pregnant women and women who have a baby less than a year old, may be eligible for special services under this Medicaid-covered program. The Perinatal High Risk Management/Infant Services System (PHRM/ISS) was established to provide enhanced services to Medicaid-eligible pregnant/postpartum women and infants with high-risk pregnancies, including case management, psychosocial and nutritional counseling, home visits, and health education.

Because of maternal complications during pregnancy associated with prematurity, MSDH adopted 17P for pregnant women across the state. Some mothers even choose early C-section delivery electively. Many studies document the effectiveness of a drug known commonly as 17-P. Weekly 17-P injections can delay premature delivery by several weeks. As discussed earlier in

this report, every week counts towards better health for mother and infant and lowered costs for the care of the infant born too soon. Too often mothers or physicians choose early C-section. Early elective C-section provides convenience to physicians and mothers and helps ascertain the date of birth, such as scheduling a birth to coincide with the birthday of another family member. However, the normal gestational period for human infants is 40 weeks (3), and all pregnancies should last at least 39 weeks before delivery (unless there is a medical complication) to result in the healthiest mother and baby.

With low birthweight being an important predictor of infant mortality, MSDH initiated several projects to assure quality, competent care to improve health outcomes. The implementation of text4baby, developed by the Healthy Mothers, Healthy Babies Coalition, has helped with the number of pregnant women receiving early and regular messages about prenatal care.

The Family Planning Waiver Program helped to provide adequate health services to clients who otherwise may not have received medical care. Educational materials, counseling and long term contraceptive methods were provided to clients to promote healthier mothers.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide referral for transportation needed		X		
2. Encourage and monitor medical appointments		X		
3. Offer Health Education group classes		X		
4. Increase referrals to Family Planning		X		
5. Establish 3 infant review board committees				X
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The PHRM/ISS program continues to focus on ensuring that moms who deliver preterm or small for gestational age infants are enrolled in a family planning program to space the next baby and help to assure a healthy mom prior to becoming pregnant again. The PHRM program continues to provide preconception counseling and care coordination for high risk clients. Folic acid is provided to all clients of reproductive age. MSDH staff assist eligible clients with finding a doctor for their pregnancy and for their baby, medical referrals, delivery planning, health information and diet advice, and the planning of their families. Home visits are made to assist clients with other basic needs and provide resources.

The PHRM/ISS program received a grant to add a research based curriculum, Partners for a Healthy Baby, and applied it to the Healthy Families America case management model. In addition, an electronic data collection program was developed to provide reports to Division of Medicaid and other organizations. This data will be used for program analysis and a guide for further program enhancements. A collaborative state stakeholders group has been developed to address case management needs of pregnant women.

#### **c. Plan for the Coming Year**

PHRM/ISS will continue to provide services related to nutrition, education, outreach activities, smoking, lack of appropriate medical care, obesity, and other risk factors associated with negative pregnancy outcomes and poor infant development. The PHRM/ISS program will continue statewide case management of high risk pregnant women and infants, while working to

transition to an evidence based model, Healthy Families America (HFA). The transition will continue with the addition of a standard statewide curriculum and then the implementation of two pilot districts for implementing HFA.

A gradual roll out of training for Healthy Families America (HFA) and a new database for HFA will occur. By June 2015, half the state will be utilizing HFA for three populations: preterm births, pregnant teenagers and women with EDC dates less than 14 months from a prior pregnancy. This population will receive three years postpartum intervention, addressing interconception care and care of the infant.

**State Performance Measure 2:** *Rate of pregnancy per 1,000 female adolescents aged 15-19 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			72.9	72.6	72.3
Annual Indicator		62.7	57.6	53.1	53.1
Numerator		6928	6156	5513	5513
Denominator		110474	106822	103793	103793
Data Source		MSDH - Vital Statistics	MSDH - Vital Statistics	MSDH - Vital Statistics	MSDH - Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	72	71.7	71.7	71.7	71.7

**Notes - 2013**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**Notes - 2012**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**a. Last Year's Accomplishments**

Notably, the teen pregnancy rate for Mississippi as across the nation has declined. This decline has been attributed both to more adolescents waiting to have sexual intercourse and to increased contraceptive use. Teen pregnancy rates also declined across all major racial and ethnic groups. Mississippi State Department of Health (MSDH) staff continued to work on Governor Phil Bryant's Healthy Teens for A Better Mississippi Teen Pregnancy Prevention Taskforce (HTBM) and developed a comprehensive strategic state plan to decrease teenage pregnancy. MSDH staff participated on HTBM subcommittees with other state and community stakeholders to get across the most effective way to prevent unplanned or unintended pregnancies. MSDH and MS Department of Human Services (MDHS) applied for but did not receive funding for a Pregnancy Assistance Grant through the United States Department of Health and Human Services, Office of Adolescent Health, to assist expecting and parenting teens achieve reproductive life planning, educational, and career goals. Healthy Teens for A Better Mississippi Teen Pregnancy Prevention Taskforce continues to conduct town hall meetings to address teen pregnancy; launch social marketing campaigns, Stomp Out Teen Pregnancy; and partnered with other community and medical facilities to conduct the Community Health Advocate Training, a medically accurate,

health education curriculum for youth and adults interested in reducing health disparities within varied communities.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain MSDH participation with national, state and community partners to develop strategies to address teen pregnancy, adolescent sexual health disparities, teen parenting and other reproductive health issues				X
2. Strengthen community partnerships to reduce teen pregnancy and adolescent sexual and reproductive health issues				X
3. Support a Statewide Preconception Health Program and Awareness Initiative			X	
4. Increase collaboration between colleges and universities involved in the Preconception Peer Education (PPE) Training Program				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Title X Family Planning Program continues to focus on the role of males by addressing beliefs and behaviors of adolescent males as it relates to pregnancy prevention. The Title X program is working with church ministries and community health centers to provide education and outreach activities for teens and young adults to prevent teen pregnancy. The MSDH Family Planning Program has established contracts with 33 Delegate Agency Providers which include: 30 CHCs located in Public Health Districts I, II, III, IV, V, and VIII; two (2) Job Corps Centers located in Public Health Districts I and V; one (1) Teen Wellness Clinic; and one (1) University Student Health Center located in Public Health District V. Several of these entities have access to or are located in school based clinic settings (Aaron E. Henry Community Health Center in District I, MS Job Corp Center in District V, and Finch Henry Job Corp Center in District I) and service a larger population of teens. All provide contraceptive supplies, education, and counseling (supplies are provided by MSDH Family Planning Program funded through Title X).

**c. Plan for the Coming Year**

MSDH continues to train MCH/Family Planning Coordinators to ensure understanding of the problem and how to best emphasize the benefits of family planning and preconception health care. Each family planning client is provided with education and counseling around preconception care and interconception care.

The Title X program strengthens community partnerships statewide to reduce teen pregnancy and adolescent sexual and reproductive health issues through education, counseling and health fairs, church workshops, etc. The Title X program staff continue to compile and distribute the Teen Pregnancy Fact Sheets raising public awareness of local teen pregnancy impact. The fact sheets list the number of students who drop out of school, require public support, and have poor pregnancy outcomes or abortions. Local government, media, community action groups, schools, and other interested parties receive these sheets along with information about the MSDH Family Planning Program in an effort to combat teen pregnancy.

The MSDH and MDHS continue to jointly lead Governor Phil Bryant's Healthy Teens for A Better Mississippi Teen Pregnancy Prevention Taskforce and work to implement strategies to reduce teenage pregnancy by 2017. The cross-section of MSDH staff continues to participate on HTBM subcommittees with other community stakeholders. The Adolescent Health Coordinator will maintain work with Governor Bryant's Office on the HTBM Initiative.

**State Performance Measure 3:** *Percent of students in grades 9-12 who met recommended levels of physical activity.*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			41.7	43.7	45.7
Annual Indicator		39.7	42.3	42.3	42.3
Numerator		53687	58980	58980	58980
Denominator		135120	139522	139522	139522
Data Source		Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	47.7	49.7	49.7	49.7	49.7

**Notes - 2013**

Note for report of 2013 data: The most readily available data is from 2011. Data are from 2011 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator. The 2013 YRBSS will be available in the Spring of 2014.

**Notes - 2012**

Note for report of 2012 data: The most readily available data is from 2011. Data are from 2011 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator.

**Notes - 2011**

Note for report of 2011 data: Data are from 2011 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator.

**a. Last Year's Accomplishments**

According to the Mississippi 2011 Youth Risk Behavioral Survey, the rate of obesity among Mississippi high school students is 16.5 percent, compared to 18.1 percent in 2009. This rate in obesity among Mississippi high school students (grades 9-12) represents a 12.7 percent drop, from the number one spot to number five in obesity nationwide.

A new report from the Robert Wood Johnson Foundation finds Mississippi leading in efforts to lower childhood obesity rates. Data collected between 2005 and 2011 shows a 13.3 percent

overall decline in childhood obesity in Mississippi. A focus on higher nutritional standards in schools is being cited as a contributor to the decline. The report may be accessed at [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf401163](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401163). Another initiative cited in Mississippi as beneficial is the "Fruits and Veggies -- More Matters" program, which is presented to a variety of establishments, including offices and schools. During 2013, the MSDH Community and School Health Bureau in partnership with the MDE implemented a total of 28 shared use agreements within schools and communities throughout state. With the passage of House Bill 540 during the 2012 Mississippi legislature, Mississippi mandates that, other than limited exceptions, school districts and school district employees may not be held liable for any claim resulting from a loss or injury arising from the use of indoor or outdoor school property or facilities made available for public recreation or sport during non-school hours. In response to House Bill 540, MSDH and MDE developed a Best Practices Tool Kit for Shared Use Agreements in Mississippi to encourage, support, and provide technical assistance that address concerns of schools/businesses/communities wanting to enter into formal shared use agreements.

A total of 11 professional development trainings were held throughout the state in collaboration with MDE, Public Health District Educators, local school districts and schools that provided instruction on physical education curriculum and classes as well as information regarding Mississippi's physical education requirements. Approximately 463 school physical education and nutrition staff along with school nurses participated in the trainings.

MSDH and MDE also provided trainings and technical assistance to local school districts and schools regarding the Coordinated School Health Program School Health Index and School Health Councils. For example in January 2013, the MSDH partnered with MDE along with the Partnership for a Healthy MS, the Bower Foundation, HealthWorks, the University of Mississippi Medical Center and the University of Southern Mississippi to host a Wellness Summit in Gulfport, MS. The event was a great success with 152 registrants including teachers, faculty, staff and principals from 30 different school districts across the state. The Summit included the following workshops: Move to Learn!; Tools for Teaching Health Topics in Mississippi; Shared Use Agreements - Making the Most of Available Resources; De-Mystifying the School Health Index; Marketing Your Child Nutrition Program; Growing a Healthy School Health Council; Healthy Living Program; The Kinesthetic Classroom -- Teaching and Learning through Movement; How Fitness affects Academics, Attendance and Discipline; Making the Most of 150 Minutes of Physical Activity; Staff Wellness: Overlooked and Undervalued.

The summit also provided these school districts training to enable them to (1) identify the strengths and weaknesses of school health and safety policies; (2) develop an action plan for improving student health; and (3) engage teachers, parents, students, and the community in improving school health policies.

MSDH collaborated with the Partnership for a Healthy MS to provide technical assistance to seventeen (17) schools/districts in order to ensure their School Health Councils are active and functioning as intended by state law.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage and/or adopt wellness policies in schools				X
2. Establish and direct local wellness councils in schools and worksites				X
3. Conduct health promotion activities for public school staff		X		
4. Provide school health education using several of the eight Coordinated School Health elements			X	
5. Implement and maintain Shared Use Agreements among				X



Mississippi school districts and communities				
6. Provide professional development for school and district staff on evidence-based strategies for the development, implementation and evaluation of multi-component physical education policies		X		
7. Provide technical assistance to school and district staff on evidence-based strategies for the development, implementation and evaluation of multi-component physical education policies		X		
8. Provide professional development to school and district staff regarding implementation of healthy school nutrition, including sodium reduction practices		X		
9. Provide technical assistance as needed to school and district staff regarding implementation of healthy school nutrition, including sodium reduction practices		X		
10.				

#### **b. Current Activities**

The MSDH Office of Preventive Health will continue its partnership with MDE Office of Healthy Schools to conduct professional development activities and provide technical assistance to school and public health district staff regarding evidence-based strategies that promote recess, multi-component physical education policies, and sodium reduction practices. Additional professional development and technical assistance opportunities will be provided by the MSDH Office of Preventive Health, Office of Child Care Facilities Licensure and MDE to early childhood education (ECE) center staff regarding implementing physical activity strategies, regulations, and policies.

#### **c. Plan for the Coming Year**

Continue to implement/maintain activities described in the two sections above.

**State Performance Measure 4:** *Percent of students in grades 9-12 who reported current cigarette use, current smokeless tobacco use, or current cigar use.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective			27.9	27.3	26.7
Annual Indicator		27.6	27.7	27.7	27.7
Numerator		35838	37647	37647	37647
Denominator		129837	136147	136147	136147
Data Source		Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual	26.2	25.7	25.7	25.7	25.7

Performance Objective					
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#### **Notes - 2013**

Note for report of 2013 data: The most readily available data is from 2011. Data are from 2011 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator. The 2013 YRBSS will be available in the Spring of 2014.

#### **Notes - 2012**

Note for report of 2012 data: The most readily available data is from 2011. Data are from 2011 Youth Risk Behavior Surveillance System; tobacco products include cigarettes, cigars, chewing tobacco, snuff, and dip. Data shown are weighted counts that represent the population estimate for the indicator.

#### **Notes - 2011**

Note for report of 2011 data: Data are from 2011 Youth Risk Behavior Surveillance System; tobacco products include cigarettes, cigars, chewing tobacco, snuff, and dip. Data shown are weighted counts that represent the population estimate for the indicator.

#### **a. Last Year's Accomplishments**

MSDH OTC partnered with the Partnership for a Healthy Mississippi to implement tobacco prevention programs and activities for youth in grades K-12. An interactive CD was distributed for use in classrooms to educate youth in grades K-6 on the dangers of tobacco use and secondhand smoke. MSDH OTC also partnered with the American Lung Association of MS to implement tobacco prevention programs and activities for middle and high school aged youth. In an additional effort to reach youth in grades K-12, MSDH OTC launched a statewide tobacco prevention media campaign. The MSDH works with partners to evaluate the effectiveness and relevance of the existing media campaign for youth in grades 7-12 to ensure that the most appropriate strategies and messages are used to reach the target audience.

Seventy-eight MS cities and towns passed comprehensive smoke-free air ordinances. Previously, smoke-free air partners assisted the MS Senate in introducing a statewide comprehensive smoke-free air bill, which unfortunately did not pass the Legislature.

The MSDH Child and Adolescent Health Program staff worked with the MSDH OTC to promote a statewide tobacco prevention and cessation program in middle and high schools. The Adolescent Health Program provides health education materials and resources for awareness events. The MSDH Office of Oral Health worked with the MSDH OTC to promote tobacco control programs among community organizations statewide.

The MSDH OTC implemented a range of integrated tobacco prevention programmatic and awareness activities statewide to educate youth in grades K-12 on the harmful effects of tobacco and to deter the initiation of tobacco use. Approximately 71,000 MS youth in grades K-12 are currently involved in youth tobacco prevention programs.

The MSDH OTC worked with partners to engage youth in grades 7-12 in more grassroots tobacco prevention and advocacy activities statewide. The Leadership, Engagement, and Activism Development (L.E.A.D.) conferences for youth in grades 9-12 were held with more than 760 high school students participating in the events. Students attending the L.E.A.D. conferences learned leadership and advocacy skills and strategies to create change in their communities related to reducing youth tobacco use. Skills gained from the conferences will be used by tobacco control program teams and youth involved with the Mississippi Tobacco-Free Coalitions.

Additional youth events held to inspire leadership and promote advocacy include SMART trainings (Students Mobilizing through Advocacy to Reshape Tomorrow) for students in 10th-12th grades and iFLY conferences (Inspiring Future Leaders Youth) for students in 7th-8th grades.

The Office of Tobacco Control provided funding to 33 Mississippi Tobacco-Free Coalitions (MTFC) to work in all 82 counties to implement tobacco control programs at grassroots levels.

Each MTFC conducted tobacco control programmatic and awareness activities throughout the year that contained messages for youth and adults. The MTFCs worked to increase tobacco-free policies in municipalities statewide and promoted the use of tobacco prevention curricula in schools.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide classroom education on the risks of smoking		X		
2. Maintain partnership to promote and provide tobacco education in middle and high schools			X	
3. Establish partnerships to implement education on the dangers of tobacco and secondhand smoke in child care centers			X	
4. Implement a statewide media campaign for youth in grades K-12			X	
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The MSDH OTC continues to work with the Partnership for a Healthy MS and the American Lung Association of MS to implement a range of integrated tobacco prevention programmatic and awareness activities statewide to educate youth in grades K-12 on the harmful effects of tobacco and to deter the initiation of tobacco use. Over 70,000 MS youth in grades K-12 are currently involved in youth tobacco prevention programs.

The MSDH OTC continues to work with partners to engage youth in grades 7-12 in more grassroots tobacco prevention and advocacy activities statewide, such as the Leadership, Engagement, and Activism Development (L.E.A.D.) conferences and SMART (Students Mobilizing through Advocacy to Reshape Tomorrow) trainings. These youth conferences allow students to learn leadership and advocacy skills and strategies to create change in their communities related to reducing youth tobacco use. Skills gained from the conferences will be used by tobacco control program teams and youth involved with the MS Tobacco-Free Coalitions (MTFC).

A total of 78 MS Cities and towns have passed comprehensive smoke-free air ordinances. The MSDH OTC continues to encourage smoke free air partners to assist the MS Legislature in introducing a statewide comprehensive smoke free air bill.

The MSDH OTC continues to collaborate with the MSDH Adolescent Health program to provide tobacco prevention programs at schools and community-based organizations for youth in grades K-12.

#### **c. Plan for the Coming Year**

In collaboration with various partners, MSDH OTC will continue to provide tobacco control resources statewide to prevent initiation of tobacco use among youth and promote cessation services. MSDH OTC will continue to work with partners to engage youth at the local level in advocacy activities related to reducing tobacco use among youth in their communities.

In an additional effort to reach middle and high school students most at risk for tobacco use, OTC will launch targeted campaigns to reach these peer groups. Focus groups were completed earlier this year to identify peer crowds and those at highest risk for tobacco use. The MSDH will continue to utilize data collected from media campaign research and the Youth Tobacco Survey to determine the effectiveness of these targeted campaigns.

The MSDH OTC continues to partner with other MSDH programs to promote tobacco control resources statewide. MSDH OTC developed and implemented an educational program to address the dangers of tobacco use and secondhand smoke for use in MS child care centers. This tobacco control program will increase awareness of the health impact of secondhand smoke exposure on children and help families take action to protect children from these health risks.

The Office of Child and Adolescent Health will continue to collaborate with OTC to coordinate statewide tobacco prevention and advocacy activities targeted for youth in grades K-12.

The MSDH OTC will increase efforts with the Mississippi Department of Mental Health, Division of Alcohol and Drug Abuse to provide targeted education and training to retailers on state laws that prohibit the sale of tobacco to individuals less than 18 years of age.

**State Performance Measure 5:** *Percent of students in grades 9-12 who reported current alcohol, marijuana or cocaine use.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective			42.1	41.2	40.4
Annual Indicator		43.8	41.6	41.6	41.6
Numerator		55078	53869	53869	53869
Denominator		125662	129502	129502	129502
Data Source		Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	39.6	38.8	38.8	38.8	38.8

**Notes - 2013**

Note for report of 2013 data: The most readily available data is from 2011. Data are from 2011 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator. The 2013 YRBSS will be available in the Spring of 2014.

**Notes - 2012**

Note for report of 2012 data: The most readily available data is from 2011. Data are from 2011 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator.

**Notes - 2011**

Note for report of 2011 data: Data are from 2011 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator.

**a. Last Year's Accomplishments**

The MSDH Office of Child and Adolescent Health provided age-appropriate health education resources and information related to safety and injury prevention and positive youth development to Students Against Destructive Decisions (SADD) Chapters at middle and high schools and supported the annual Teens On The Move Summit. The Office of Child and Adolescent Health partnered with the Mississippi Department of Public Safety and DREAM, Inc. to support middle and high school student leaders in organizing the summit.

In 2014, the Offices of Child and Adolescent Health and Preventive Health, along with other community health partners, planned "Safety Blast-Off" Day, a safety and injury prevention and awareness event held in May at Jackson Public School's Adopt-A-School Partner, McWillie Elementary School. Students and staff participated in all of the campus-wide safety awareness and injury prevention educational activities from experts in a child-friendly environment. Safety professionals shared valuable information and provided exciting demonstration on topics related specifically to youths.

The Office of Child and Adolescent Health partners with the Office of Tobacco Control, the Partnership For A Healthy Mississippi, and Generation FREE to promote smoking cessation and tobacco education throughout the state to adolescents.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the Mississippi Department of Mental Health, Bureau of Alcohol and Drug Abuse State Plan				X
2. Maintain MSDH Adolescent Health Program participation in Students Against Destructive Decisions (SADD)				X
3. Develop and implement an initiative to educate and provide health information to adolescents, parents and community stakeholders about the negative impact of alcohol, tobacco, and other substance abuse issues		X		
4. Identify opportunities for collaborating to reduce alcohol, tobacco and other substance abuse issues affecting middle and high school and college students				X
5. Provide training opportunities, health education information and resource material for public health department district and county level staff related to alcohol, tobacco and substance issues affecting middle and high school and college students				X
6. Provide health education information and resource material throughout the state of various alcohol, tobacco and other substance issues affecting adolescents and young adults				X
7.				
8.				
9.				

10.				
-----	--	--	--	--

#### **b. Current Activities**

The MSDH Adolescent Health Program collaborates with the Mississippi Department of Mental Health, Bureau of Alcohol and Drug Abuse, DREAM, Inc. and FTC, Inc. to promote education and awareness activities related to the use of alcohol and other drugs.

Currently, the MSDH Adolescent Health Program partners with the Mississippi Community Leaders and Interfaith Partnerships (MCLIP) in collaboration with the Substance Abuse and Mental Health Services Administration and the Mississippi Department of Mental Health, Bureau of Alcohol and Drug Services to bring together representatives of faith-based organizations and the community to develop strategies for providing care and support in the areas of health, mental health, and substance abuse. The group works together to address the health and behavioral health needs of the entire family and community.

The MSDH Adolescent Coordinator works to build partnerships with major stakeholders and community leaders to reduce alcohol and substance use among adolescents and young adults.

#### **c. Plan for the Coming Year**

The MSDH Office of Child and Adolescent Health will provide age-appropriate health education resources and information related to safety and injury prevention and positive youth development to Students Against Destructive Decisions (SADD) Chapters at middle and high schools.

The MSDH Adolescent Health Program will continue building partnerships with the Mississippi Bureau of Narcotics to provide education and outreach to adolescents in Mississippi.

The MSDH Adolescent Health, along with the University of Mississippi Medical Center, Mississippi Chapter of the American Academy of Pediatrics, DREAM, Inc., and Youth Leadership Jackson will work to promote youth-friendliness trainings statewide to increase the appropriateness of communications directed at adolescents in Mississippi.

The MSDH Adolescent Health Program staff will work to build partnerships with major stakeholders and community leaders to reduce alcohol and substance use among adolescents and young adults. In order to build those partnerships, the Program will conduct a system capacity assessment, with guidance from the State Adolescent Health Coordinator Resource Center at the University of Minnesota. Internal and external partners engaged through the assessment will serve to expand and refine all programmatic activities.

#### **State Performance Measure 7: *Rate of Chlamydia, gonorrhea, and syphilis cases per 100,000 women aged 13-44 years.***

##### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective			2874	2730.3	2593.8
Annual Indicator	3,427.0	3,025.3	2,945.7	3,176.5	2,367.3
Numerator	22119	19542	19028	20519	15292
Denominator	645432	645963	645963	645963	645963
Data Source	MSDH - STD/HIV	MSDH - STD/HIV	MSDH - STD/HIV	MSDH - STD/HIV	MSDH - STD/HIV

	Program	Program	Program	Program	Program
Is the Data Provisional or Final?				Final	Provisional
	2014	2015	2016	2017	2018
Annual Performance Objective	2464.1	2340.9	2340.9	2340.9	2340.9

#### **a. Last Year's Accomplishments**

A proactive training calendar of courses utilizing the guiding principles of CDC's curriculum was developed to provide education and reduce stigma throughout the state of Mississippi. The training courses were extended to health department staff, community planning group members, health care professionals, and other interested community stakeholders. The Education Branch staff worked collaboratively with the Mississippi STD Prevention Training Center (MSPTC) and Mississippi AIDS Education Training Center (AETC) to promote education and training for healthcare professionals within Mississippi. Staff distributed 4,844 educational materials last year.

The staff within the Education Branch coordinated and trained 203 participants on STD/HIV. The Education Branch staff conducted presentations in prioritized communities to increase awareness, promote testing, and develop partnerships for educating communities at risk. Educational trainings offered by the Education Branch included the following:

- STD/HIV Instructor Course
- Fundamentals of HIV Prevention
- Fundamentals of HIV Prevention: Addressing Issues of Youth
- Comprehensive Risk Counseling Services

STD/HIV Office staff collaborated with some state universities to build their capacity to provide STD screening and treatment opportunities through their student health centers utilizing MSDH supplies and the MSDH Laboratory to process specimens. A protocol was written to pilot this process with two universities. Through CDC funding for HIV prevention and screening, the STD/HIV Office increased the number of rapid HIV test sites to reach at risk populations for HIV screening.

As part of comprehensive prevention with positives project, MSDH distributed 1,405,900 condoms through health departments, community partners, CBOs, and other non-traditional partners.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand chlamydia and gonorrhea screening and treatment throughout the state			X	
2. Partner with community based organizations to provide syphilis and HIV screenings in at-risk communities			X	
3. Collaborate with high schools to provide STD/HIV education and screenings			X	
4. Develop media campaigns to create STD/HIV awareness within the community			X	
5.				
6.				
7.				
8.				

9.				
10.				

#### **b. Current Activities**

The STD/HIV Office is working attentively to reduce stigma and promote awareness of HIV/AIDS throughout the state of Mississippi. Currently, the STD/HIV Office and Office of Communications with the MSDH coordinate educational opportunities by utilizing information technology (i.e., MSDH website, Face book, and Twitter). The partnership of the STD/HIV Office and Office of Communication demonstrates awareness for the following:

- National Black HIV/AIDS Awareness Day
- STD Awareness Month -- April
- National Week of Prayer for the Healing of AIDS
- National Women and Girls HIV/AIDS Awareness Day
- National HIV Testing Day
- National Hepatitis Day

The STD/HIV Office Education Branch also utilizes educational trainings, educational toolkits and webinars to reach various clinicians, nurses, health care workers, and community workers to increase awareness for STDs. The development of a social marketing campaign with Maris, West and Baker enhance STD/HIV awareness within Public Health Districts III, V and IX. This campaign will target specific populations the public health districts with the highest rates of infection for HIV and other STDs. The campaign will include advertisement thru digital billboards, bus transportation, and educational brochure.

The STD/HIV Office is conducting free chronic Hepatitis B & C testing at all County Health Departments as a part of Hepatitis Awareness Month in May.

#### **c. Plan for the Coming Year**

The STD/HIV Office continues to foster awareness and reduce stigma throughout the state of Mississippi. The implementation of online course registration continues to increase course recruitment and participation.

Future plans are to provide STD/HIV education and screenings within high schools. We also plan to educate stakeholders on emerging STD/HIV trends to plan appropriate interventions. Further, the STD/HIV Office seeks to build more collaboration with Federally Qualified Health Centers to increase STD screening among at risk populations, including the Jackson/Hinds Comprehensive Health Center. The STD/HIV Office is striving to increase syphilis and HIV screening in high morbidity areas.

**State Performance Measure 8:** *Percent of women aged 18-44 years who received an influenza vaccination within the last year.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective			6	6	6
Annual Indicator		5.2	43.1	43.1	43.1
Numerator		4734	14249	14249	14249
Denominator		90786	33032	33032	33032
Data Source		MSDH - Communicable	MS	MS	MS



		Diseases Immunization Program	PRAMS	PRAMS	PRAMS
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	50	50	50	50	50

#### Notes - 2013

Note for report of 2013 data: Data are from 2010 Mississippi Pregnancy Risk Assessment Monitoring System survey, Flu Supplement. Percentage represents women who self-reported having a H1N1 shot or a seasonal influenza shot.

#### Notes - 2012

Note for report of 2012 data: Data are from 2010 Mississippi Pregnancy Risk Assessment Monitoring System survey, Flu Supplement. Percentage represents women who self-reported having a H1N1 shot or a seasonal influenza shot.

#### Notes - 2011

Note for report of 2011 data: Data are from 2010 Mississippi Pregnancy Risk Assessment Monitoring System survey, Flu Supplement. Percentage represents women who self-reported having a H1N1 shot or a seasonal influenza shot.

#### a. Last Year's Accomplishments

The MSDH Immunization Program provided influenza vaccines to pregnant women who sought health care at local MSDH county health departments.

PRAMS data is also used to help determine the appropriate indicator for this measure. Patient Information Management System (PIMS) data only captures patients that visit MSDH clinics whereas PRAMS data captures both MSDH and non-MSDH populations that are targeted by this measure.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide influenza vaccinations to women in local MSDH county health departments	X			
2. Continue to educate pregnant women on the importance of receiving an annual influenza vaccination		X		
3. Continue to educate pregnant women on the benefits of receiving Tdap vaccinations during the last half of their pregnancy		X		
4. Continue to provide Tdap vaccinations to pregnant women in local MSDH county health departments	X			
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

The MSDH provides influenza vaccines to pregnant women of childbearing age and others who seek health care at local MSDH county health departments. Influenza vaccine is offered

statewide to target populations and others.

MSDH supports CDC and ACIP recommendations to administer Tdap vaccine to pregnant women during the last half of their pregnancy.

### c. Plan for the Coming Year

MSDH will continue to promote and provide influenza vaccine to women of childbearing age and others and work with other healthcare partners to encourage all clients, including ones with chronic conditions, to get influenza vaccines.

MSDH continues to promote and provide Tdap vaccine to women who have not yet received a single dose of Tdap and others to promote cocooning. Cocooning is the immunization of family members and close contacts of a newborn to protect infants from disease until they have built up immunity through their own immunizations.

### State Performance Measure 9: *Percent of women having a live birth who had a previous preterm or small-for-gestational-age infant.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			0.9	0.9	0.8
Annual Indicator		1.0	1.1	1.1	1.1
Numerator		396	434	424	424
Denominator		39984	39825	38618	38618
Data Source		MSDH - Vital Statistics	MSDH - Vital Statistics	MSDH - Vital Statistics	MSDH - Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	0.8	0.8	0.8	0.8	0.8

#### Notes - 2013

Note: The MS Vital Records and statistics 2013 data will be released in Fall of 2014. The most recent data available for this indicator 2012 data.

#### Notes - 2012

Note: The MS Vital Records and statistics 2013 data will be released in Fall of 2014. The most recent data available for this indicator 2012 data.

### a. Last Year's Accomplishments

The Delta Infant Mortality Elimination (DIME) project closed out the last client February 2013. The Metropolitan Infant Mortality Elimination (MIME) project closed out the last client June 2013.

MSDH has started working on data cleaning and data analysis. Database and data files were transferred from UMMC to MSDH November 2013.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Increase health education related to safe sleep of infants		X		
2. Complete data analysis				X
3. Publish findings from data analysis and lessons learned from the MIME/DIME projects				X
4. Develop individualized reproductive plans with women in the Program		X		
5. Increase referrals to Family Planning Programs		X		
6. Increase health education related to safe sleep of infants		X		
7. Develop a retrospective control cohort to match IRB DIME Women				X
8. Establish three infant review board committees				X
9.				
10.				

#### **b. Current Activities**

MSDH and UMMC work together on the data analysis plan and reporting criteria. Baseline social, medical, and obstetrical characteristics of eligible women in each cohort of the MIME project and DIME project were compared.

The effects of inter-pregnancy care (IPC) on child spacing and subsequent adverse pregnancy outcomes for women with a previous very-low-birth weight (VLBW) delivery is investigated by calculating the average number of pregnancies and the average number of adverse pregnancies within a certain time range of index delivery.

Additional information that was collected on IPC cohort, including diagnosis and treatment for acute and chronic diseases, reproductive plans, housing, employment, and educational status, are also analyzed. Data analysis will be completed by the end of 2014.

Women who participate in the PHRM/ISS program receive interconception care addressing birth spacing and care for small for gestational age infants.

#### **c. Plan for the Coming Year**

MSDH and UMMC will continue to work together on manuscript writing and looking for opportunities to publish findings from data analysis and lessons learned from the MIME/DIME project.

Preconception care is provided and is being revisited to ensure that all components of health care are addressed to improve the health of women. A gradual roll out of training for Healthy Families America (HFA) and a new database for HFA will occur.

By June 2015, half the state will be utilizing HFA for three populations: preterm births, pregnant teenagers and women with EDC dates less than 14 months from a prior pregnancy. This population will receive three years postpartum intervention, addressing interconception care and care of the infant.

**State Performance Measure 11:** *The percent of women whose live birth occurred less than 24 months after a prior birth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Performance Objective					21.8

Annual Indicator		25.4	24.0	22.8	22.8
Numerator		5937	5603	5168	5168
Denominator		23387	23391	22639	22639
Data Source		MS Vital Statistics	MS Vital Statistics	MS Vital Statistics	MS Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Annual Performance Objective	21.8	21.8	21.8	21.8	21.8

#### **a. Last Year's Accomplishments**

After much deliberation by the Mississippi Title V MCH Block Grant Work Group, a group comprised of maternal and child health stakeholders who guide the Title V application process, a unanimous decision was made to add preconception and interconception care as standalone priorities. Preconception care can improve chances of getting pregnant, having a healthy pregnancy, and having a healthy baby. Preconception care was previously listed with low birthweight and preterm birth but has now been separated out and combined with interconception care. Every woman should think about her health whether or not she is planning to become pregnant. Maternal health before, during and after pregnancy is a significant contributor to both maternal and infant morbidity and mortality. Adequate birth spacing allows for women to improve health and social risk factors and improves outcomes in pregnancy and for developing children. State Performance Measure 11 was adopted to capture data around pregnancy spacing and describe programmatic activities that encourage healthy family planning practices.

The Comprehensive Reproductive Health Program (CRHP) continued to provide comprehensive family planning services and assured that women who gave birth had access to counseling, education, medical exams, lab work and contraceptive methods to plan their families in the future. Every participant of the family planning program receives folic acid, counseling on spacing their children to ensure better health outcomes for themselves and the baby and information on the prevention of unintended pregnancies. Studies have shown that unplanned pregnancies are at a greater risk of preterm births and low birth weight babies due to 1 in 8 babies being born too early.

In addition the CRHP provides education on ways that participants can improve their overall health, such as reaching a healthy weight, making healthy food choices, being physically active, caring for your teeth and gums, reducing stress, smoking cessation, and avoiding alcoholic beverages.

The CRHP continues to provide ongoing preconception and interconception counseling and extended case management. The program has also continued to provide educational materials to encourage social behavior changes of clients.

In the past five years, the use of long-acting reversible contraception (LARC) methods continued to increase among family planning clients. From 2009 to 2013, the percentage of females using a LARC method rose from 26% to over 36%. CRHP also provides access to tubal ligations and vasectomies for Title X family planning clients who desire a permanent contraceptive method. MSDH has expanded the range of LARC contraceptive options by piloting Nexplanon in six of the nine public health districts incorporating eight clinics.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase the number of women who are utilizing long-acting		X		

reversible contraception (LARC)				
2. Increase the numbers of women who remain on Medicaid and who have ever had an adverse pregnancy outcome		X		
3. Serve as liaisons between medical homes, patient and family				X
4. Increase the percent of women who had postpartum follow-ups to prevent unintended pregnancies and promote spacing	X			
5. Conduct outreach and networking to locate and connect with at risk mothers and others, who may not be enrolled in family planning or reproductive health services		X		
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The CRHP provides the following:

- Counseling and education;
- Medical exams;
- Contraceptive methods including long-acting reversible contraception (LARC);
- Health promotion to prevent unintended pregnancies;
- Preconception and interconception health care services, to include folic acid;
- Advocacy to expand Medicaid past the 60 days of delivery.

The PHRM/ISS program works with the participants to ensure that the women are aware of family planning options, and if they qualify, work with the women to obtain family planning Medicaid, and address the importance of interconception care and spacing for the next pregnancy.

With an effectiveness rate of over 99%, LARCs can significantly reduce the number of unintended pregnancies among women in the United States. LARCs, to include IUDs (i.e., Mirena, ParaGard), Depo Provera as well as implants (i.e., Nexplanon) are long lasting (between 3-12 years), highly effective (over 99%) and reversible, making them ideal for preventing pregnancy. Once inserted by a trained clinician, LARCs do not require further maintenance. This reduces the risk of improper use which may lead to an unintended pregnancy. LARCs offer birth control that is safe, effective and forgettable.

#### **c. Plan for the Coming Year**

The CRHP plans to provide the following:

- Increased integrative preconception and interconception health care topics in its existing program;
- Identification of additional at risk individuals that have increased reproductive health needs;
- Increased engagement in outreach activities to promote reproductive health education in communities statewide.
- Increased male participation in the title V and X programs as it relates to the roles of partners in improving healthy outcomes.

A gradual roll out of training for Healthy Families America (HFA) and a new database for HFA will occur. By June 2015, half the state will be utilizing HFA for three populations: preterm births, pregnant teenagers and women with EDC dates less than 14 months from a prior pregnancy. This population will receive three years postpartum intervention, addressing interconception care and care of the infant.

MSDH plans to pilot Nexplanon in at least 20 additional counties in early 2015 and statewide by the end of the year. In addition to ensuring that a broad range of acceptable and effective family planning methods are made available to all clients, CRHP plans to launch an innovative educational and outreach campaign aimed at increasing public awareness of LARC methods and benefits.

## E. Health Status Indicators

**Health Status Indicators 01A:** *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	12.7	12.1	11.8	11.6	11.6
Numerator	5702	4847	4705	4486	4486
Denominator	44904	39984	39825	38618	38618
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

### Notes - 2013

Note: The MS Vital Records and statistics 2013 data will be released in Fall of 2014. The most recent data available for this indicator 2012 data.

### Notes - 2012

Note: The MS Vital Records and statistics 2013 data will be released in Fall of 2014. The most recent data available for this indicator 2012 data.

### Notes - 2011

Note for report of 2011 data: Data from Mississippi Trauma Registry

### Narrative:

Since 2011, MSDH has collaborated with hospitals, physicians, community organizations and March of Dimes on the Healthy Babies Are Worth the Wait initiative in an effort to reduce elective deliveries prior to 39 weeks. Education is provided to pregnant patients, health care providers and the greater community on the risk of preterm birth and what measures can be taken to reduce complications. This remains an ongoing focus for statewide change in attitudes, behaviors and quality improvement in obstetrics. Thirty-six of Mississippi's forty-five delivery hospitals (80%) have committed to reduce unnecessary early elective deliveries to 5% or less of all births. Six hospitals have already met this goal.

MSDH Maternity Services Program continues to provide high quality, early comprehensive, risk appropriate prenatal and postpartum care utilizing an interdisciplinary team consisting of nurses, nurse practitioners, physicians, nutritionists and social workers located in county health departments in an effort to reduce low-birth weight, infant and maternal mortality and morbidity in Mississippi. During CY 2013, approximately 14 percent of the women who gave birth in Mississippi received their prenatal care in county health departments (compared to 18 percent in 2012, 19 percent in 2011, 18 percent in 2010, 17 percent in 2008 and 2009 and 19 percent in CY

2007). WIC is a critical component of the maternity care effort.

A part-time, board-certified OB/GYN continues to provide consultation statewide for the maternity, BCCP, and family planning programs. All maternity clients are evaluated by the county public health team for perinatal risk at every clinic visit. The public health team at the district and county level evaluates the maternity patient at each visit, using protocols which reflect national standards of care for maternity patients. Management of care is based on the level of perinatal risk reflecting national standards of care. Maternity clients and her family are encouraged to participate in developing skills and resources for future problem solving and wellness promotion. Special emphasis is placed on the identification of high-risk factors and ensuring appropriate care to reduce or prevent problems. This includes referring for delivery by an obstetrician at hospitals that provide the necessary specialized care for the mother and her baby. Ongoing communication is maintained to ensure continued access to needed services.

**Health Status Indicators 02B:** *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Indicator	1.9	1.7	1.7	1.7	1.7
Numerator	826	671	663	645	645
Denominator	43452	38616	38431	37349	37349
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2013**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**Notes - 2012**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**Narrative:**

The Perinatal High Risk Management/Infant Services System (PHRM/ISS) case management program is provided to target populations who have insufficient resources. The program's multidisciplinary team (Mississippi licensed RN, Nutritionist/Registered Dietitian, and Social Worker) provides a comprehensive approach to high-risk mothers for enhanced services. Targeted case management combined with the team approach establishes better treatment of the whole patient, improves the patient's access to available resources, provides for early detection of risk factors, and allows for coordinated care, all in order to reduce the incidence of low birthweight and infant and maternal mortality and morbidity. This team of professionals provides risk screening assessments, counseling, health education, home visiting, and monthly case management.

**Health Status Indicators 03A:** *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Indicator	16.7	13.9	14.9	14.6	14.6
Numerator	106	87	93	91	91
Denominator	634548	624876	623581	621204	621204
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2013**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**Notes - 2012**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**Narrative:**

In 2013, the Offices of Child and Adolescent Health and Preventive Health, along with other community health partners, arranged "Safety Blast-Off" Day, a safety and injury prevention and awareness event held in May at Jackson Public School's Adopt-A-School Partner, McWillie Elementary School. Students and staff participated in all of the campus-wide safety awareness and injury prevention educational activities from experts in a child-friendly environment and received certificates of completion for participating in the event. Safety professionals shared valuable information and provided exciting demonstration on the topics: Fire Safety, Seatbelt Safety and Demonstration, Pedestrian and Bicycle Safety, American Medical Response (AMR), Alcohol and Drug Prevention Safety, Tobacco Prevention Safety, Healthy Habits for Life Eating, Nutrition and Physical Activity, Distractive Driving, Water Safety, and Transportation and School Bus Safety. College student volunteers assisted with the planning and organizing of the safety awareness event.

The Division of Injury and Violence Prevention has conducted trainings to provide information on preventing intentional and unintentional injuries to communities across the state.

**Health Status Indicators 03B:** *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Indicator	6.9	4.2	7.2	6.8	6.8
Numerator	44	26	45	42	42
Denominator	634548	624876	623581	621204	621204
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a					



3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2013**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**Notes - 2012**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**Narrative:**

In 2013, 2,500 child restraints were distributed across the state of Mississippi.

The Division of Injury and Violence Prevention conducted 70 culturally competent, publicized child safety seat checkpoints at local health departments, community events, shopping centers, pre-schools, and health/safety fairs to promote correct usage statewide. Health Educators and staff from Mississippi Safe Kids advertised the checkpoints by sending out flyers, email list serves, and advertised through the local health departments.

All MSDH Public Health Districts have partnered with at least two local police departments to check and install safety seats and promote proper child safety/seat belt usage.

**Health Status Indicators 03C:** *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	43.1	28.0	32.1	27.8	27.8
Numerator	189	122	140	121	121
Denominator	438136	435513	436233	435250	435250
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2013**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**Notes - 2012**

Note: The MS Vital Records 2013 data will be released in the Fall of 2014. The most recent data available for this indicator is 2012 data.

**Narrative:**

The Division of Injury and Violence Prevention partnered with the Mississippi Department of Public Safety (MDPS) to conduct activities that promote safe driving and seat belt usage for teens in Mississippi.

The Division of Injury and Violence Prevention inspected District Health Educators to assure they

were demonstrating effective strategies in addressing risk behaviors related to intentional and unintentional injuries.

**Health Status Indicators 04A:** *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	580.1	617.6	642.1	576.1	477.6
Numerator	3681	3938	4004	3579	2967
Denominator	634548	637585	623581	621204	621204
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2013**

Note for report of 2012 data: Data from Mississippi Trauma Registry

**Notes - 2012**

Note for report of 2012 data: Data from Mississippi Trauma Registry

**Notes - 2011**

Note for report of 2011 data: Data from Mississippi Trauma Registry

**Narrative:**

The Office of Child and Adolescent Health, along with the Attorney General's Office, Mississippi Department of Education, MS Department of Mental Health, Mississippi Department of Human Services, and Mississippi State University's Social Science Research Center, organized the 2013 Mississippi KIDS COUNT Youth Summit. Youth participants created a state mapping of issues impacting today's adolescents and youth. The leading four issues included: bullying and harassment, teen pregnancy, alcohol and drugs, and suicide. There were student leaders selected to participate in the training summit from statewide middle and high schools in Mississippi.

In 2013, the Offices of Child and Adolescent Health and Preventive Health, along with other community health partners, planned "Safety Blast-Off" Day, a safety and injury prevention and awareness event held in May at Jackson Public School's Adopt-A-School Partner, McWillie Elementary School. Students and staff participated in all of the campus-wide safety awareness and injury prevention educational activities from experts in a child-friendly environment and received certificates of completion for participating in the event. Safety professionals shared valuable information and provided exciting demonstration on the topics: Fire Safety, Seatbelt Safety and Demonstration, Pedestrian and Bicycle Safety, Alcohol and Drug Prevention Safety, Tobacco Prevention Safety, American Medical Response (AMR), Healthy Habits for Life Eating, Nutrition and Physical Activity, Water Safety, Distracted Driving, and Transportation and School Bus Safety. College student volunteers assisted with the planning and organizing of the safety awareness event.

The MSDH Office of Child and Adolescent Health provides age-appropriate health education resources and information related to safety and injury prevention and positive youth development

to Students Against Destructive Decisions (SADD) Chapters at middle and high schools and supported the 2012 Teens On The Move Summit at the Mississippi Trade Mart in April. In 2013, the Office of Child and Adolescent Health will partner with Mississippi Department of Public Safety and DREAM, Inc. to support middle and high school student leaders in organizing the Annual Teens On The Move Summit in April.

The Child and Adolescent Health staff will continue providing age-appropriate health education resource material and information related to safety and injury prevention for children aged 14 years and younger.

The Division of Injury and Violence Prevention works to train, certify, and recertify district health educators and selected local health department staff as Child Passenger Safety Technicians in order to increase number of inspection stations available to Mississippi communities.

**Health Status Indicators 04B:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04B - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Indicator	200.6	213.3	218.4	187.2	168.9
Numerator	1273	1360	1365	1163	1049
Denominator	634548	637585	624876	621204	621204
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2013**

Note for report of 2012 data: Data from Mississippi Trauma Registry

**Notes - 2012**

Note for report of 2012 data: Data from Mississippi Trauma Registry

**Notes - 2011**

Note for report of 2011 data: Data from Mississippi Trauma Registry

**Narrative:**

The Child Passenger Safety Program plans to continue to offer National Highway Traffic and Safety Administration (NHTSA) approved certification and recertification of Child Safety Passenger Technicians (CPST) throughout the state, including staff from local health departments. At least 10 CPST courses will be taught in at least 5 different MSDH Public Health Districts. Increasing the number of certified technicians allows for a more efficient program of education and child safety seat distribution. The plan includes certification of individuals from all Public Health Districts, fire departments, police departments, and collaboration with CPSTs across the state to ensure that CPS education is dispersed to the entire target population. MSDH staff certified as CPSTs will continue to distribute child safety seats through the local Health Department clinic. All CPST courses encompass the goals and objectives of NHTSA's Standardized CPST Program and focus on the training and retraining of CPSTs, law enforcement officials, fire and emergency rescue personnel, and other professionals to teach proper installation of child safety seats to parents and caregivers. It is our desire to address retention of

our CPSTs as it is more cost efficient to retain than it is to train. A suggested plan would be to identify funding geared specifically for maintaining our CPSTs throughout the state. We would like to see tech updates done quarterly within each district to keep techs current with their CEUs and other updates.

**Health Status Indicators 04C:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 04C - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Annual Indicator	691.3	733.1	773.1	627.0	495.8
Numerator	3029	3254	3367	2729	2158
Denominator	438136	443886	435513	435250	435250
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2013**

Note for report of 2012 data: Data from Mississippi Trauma Registry

**Notes - 2012**

Note for report of 2012 data: Data from Mississippi Trauma Registry

**Notes - 2011**

Note for report of 2011 data: Data from Mississippi Trauma Registry

**Narrative:**

The Office of Child and Adolescent Health staff will continue providing age-appropriate health education resource material and information related to safety and injury prevention for youth aged 15 through 24 years.

The Adolescent Health Coordinator partnered with the Mississippi Department of Public Safety, Mississippi State Highway Patrol's Underage Drinking Division and Mississippi Department of Transportation to coordinate outreach events at college campuses statewide. Students were provided information related to underage drinking and safety and injury prevention related to motor vehicle accidents. Workshops were conducted to increase awareness of seat belt use, to reduce texting while driving and to reduce drinking and driving.

The Division of Injury and Violence Prevention partnered with the Mississippi Department of Public Safety (MDPS) to conduct activities that promote safe driving and seat belt usage for teens in Mississippi.

The Division of Injury and Violence Prevention inspected the District Health Educators to assure they were demonstrating effective strategies in addressing risk behaviors related to intentional and unintentional injuries.

**Health Status Indicators 06A:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

<b>CATEGORY</b> TOTAL POPULATION BY RACE	<b>Total All Races</b>	<b>White</b>	<b>Black or African American</b>	<b>American Indian or Native Alaskan</b>	<b>Asian</b>	<b>Native Hawaiian or Other Pacific Islander</b>	<b>More than one race reported</b>	<b>Other and Unknown</b>
Infants 0 to 1	39651	19741	18155	320	375	36	1024	0
Children 1 through 4	164177	84509	72152	1291	1351	131	4743	0
Children 5 through 9	208598	109801	89878	1698	1947	114	5160	0
Children 10 through 14	208778	110521	90972	1453	1884	97	3851	0
Children 15 through 19	211793	110378	95007	1318	1855	117	3118	0
Children 20 through 24	223457	122119	94566	1532	2586	226	2428	0
Children 0 through 24	1056454	557069	460730	7612	9998	721	20324	0

**Notes - 2015**

**Narrative:**

In 2014 through an Office of Minority Health Grant, The Office of Health Disparity Elimination entered into a contract with the National Center for Cultural Competence to provide a series of webinars among MSDH staff and federally qualified community health centers staff that focus on three areas: Cultural Competence, Linguistic Competence and the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). These trainings will facilitate an improved cross-cultural communication between Low English Proficiency (LEP) patients and the MSDH staff by providing interpretation and translation assistance to the MSDH districts, field, departments and programs. It will also encompass outreach work in the community, assist district and county level staff to understand and respond effectively to the cultural and linguistic needs of the agency patients, assist with interpretation services at the District level, provide assistance to the different MSDH departments and programs in the translation of agency materials from English to Spanish, the revision of previously translated forms, the training of interpreters, and serve outreach workers within the various communities. The MSDH Office of Health Disparity Elimination also employs Outreach Coordinators to provide guidance on multicultural perspectives including those of the Middle Eastern and Hispanic communities and to assist with the certification of MSDH translators.

**Health Status Indicators 06B:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

<b>CATEGORY</b> TOTAL POPULATION BY HISPANIC ETHNICITY	<b>Total NOT Hispanic or Latino</b>	<b>Total Hispanic or Latino</b>	<b>Ethnicity Not Reported</b>
Infants 0 to 1	37940	1711	0
Children 1 through 4	156389	7788	0
Children 5 through 9	199930	8668	0
Children 10 through 14	202325	6453	0
Children 15 through 19	205441	6352	0
Children 20 through 24	215536	7921	0

Children 0 through 24	1017561	38893	0
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#### Notes - 2015

##### Narrative:

In 2014 through an Office of Minority Health Grant, The Office of Health Disparity Elimination entered into a contract with the National Center for Cultural Competence to provide a series of webinars among MSDH staff and federally qualified community health centers staff that focus on three areas: Cultural Competence, Linguistic Competence and the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). These trainings will facilitate an improved cross-cultural communication between Low English Proficiency (LEP) patients and the MSDH staff by providing interpretation and translation assistance to the MSDH districts, field, departments and programs. It will also encompass outreach work in the community, assist district and county level staff to understand and respond effectively to the cultural and linguistic needs of the agency patients, assist with interpretation services at the District level, provide assistance to the different MSDH departments and programs in the translation of agency materials from English to Spanish, the revision of previously translated forms, the training of interpreters, and serve outreach workers within the various communities. The MSDH Office of Health Disparity Elimination also employs Outreach Coordinators to provide guidance on multicultural perspectives including those of the Middle Eastern and Hispanic communities and to assist with the certification of MSDH translators.

#### Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

##### HSI #07A - Demographics (Total live births)

<b>CATEGORY</b> Total live births	<b>Total All Races</b>	<b>White</b>	<b>Black or African American</b>	<b>American Indian or Native Alaskan</b>	<b>Asian</b>	<b>Native Hawaiian or Other Pacific Islander</b>	<b>More than one race reported</b>	<b>Other and Unknown</b>
Women < 15	90	28	62	0	0	0	0	0
Women 15 through 17	1349	525	802	13	8	1	0	0
Women 18 through 19	3429	1601	1791	24	8	3	0	2
Women 20 through 34	30582	17223	12736	189	163	226	0	45
Women 35 or older	3165	1957	1077	22	36	54	0	19
Women of all ages	38615	21334	16468	248	215	284	0	66

#### Notes - 2015

##### Narrative:

In 2014 through an Office of Minority Health Grant, The Office of Health Disparity Elimination entered into a contract with the National Center for Cultural Competence to provide a series of webinars among MSDH staff and federally qualified community health centers staff that focus on three areas: Cultural Competence, Linguistic Competence and the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). These trainings will facilitate an improved cross-cultural communication between Low English Proficiency (LEP) patients and the MSDH staff by providing interpretation and translation assistance to the MSDH

districts, field, departments and programs. It will also encompass outreach work in the community, assist district and county level staff to understand and respond effectively to the cultural and linguistic needs of the agency patients, assist with interpretation services at the District level, provide assistance to the different MSDH departments and programs in the translation of agency materials from English to Spanish, the revision of previously translated forms, the training of interpreters, and serve outreach workers within the various communities. The MSDH Office of Health Disparity Elimination also employs Outreach Coordinators to provide guidance on multicultural perspectives including those of the Middle Eastern and Hispanic communities and to assist with the certification of MSDH translators.

**Health Status Indicators 07B:** *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

<b>CATEGORY</b>	<b>Total NOT Hispanic or Latino</b>	<b>Total Hispanic or Latino</b>	<b>Ethnicity Not Reported</b>
Total live births			
Women < 15	83	1	6
Women 15 through 17	1246	39	64
Women 18 through 19	3187	80	162
Women 20 through 34	27424	962	2196
Women 35 or older	2660	128	377
Women of all ages	34600	1210	2805

**Notes - 2015**

**Narrative:**

In 2014 through an Office of Minority Health Grant, The Office of Health Disparity Elimination entered into a contract with the National Center for Cultural Competence to provide a series of webinars among MSDH staff and federally qualified community health centers staff that focus on three areas: Cultural Competence, Linguistic Competence and the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). These trainings will facilitate an improved cross-cultural communication between Low English Proficiency (LEP) patients and the MSDH staff by providing interpretation and translation assistance to the MSDH districts, field, departments and programs. It will also encompass outreach work in the community, assist district and county level staff to understand and respond effectively to the cultural and linguistic needs of the agency patients, assist with interpretation services at the District level, provide assistance to the different MSDH departments and programs in the translation of agency materials from English to Spanish, the revision of previously translated forms, the training of interpreters, and serve outreach workers within the various communities. The MSDH Office of Health Disparity Elimination also employs Outreach Coordinators to provide guidance on multicultural perspectives including those of the Middle Eastern and Hispanic communities and to assist with the certification of MSDH translators.

**Health Status Indicators 08A:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

<b>CATEGORY</b>	<b>Total All</b>	<b>White</b>	<b>Black or African American</b>	<b>American Indian or Native</b>	<b>Asian</b>	<b>Native Hawaiian or Other</b>	<b>More than one race reported</b>	<b>Other and Unknown</b>
Total deaths								

	<b>Races</b>			<b>Alaskan</b>		<b>Pacific Islander</b>		
Infants 0 to 1	342	116	205	4	3	1	2	11
Children 1 through 4	72	34	31	4	0	0	1	2
Children 5 through 9	37	12	21	3	0	0	0	1
Children 10 through 14	49	25	24	0	0	0	0	0
Children 15 through 19	123	61	57	1	0	0	0	4
Children 20 through 24	245	131	106	1	0	0	0	7
Children 0 through 24	868	379	444	13	3	1	3	25

## Notes - 2015

### Narrative:

In 2013, the Sudden Infant Death Syndrome (SIDS) Program partnered with internal and external programs at nine community events targeting childcare workers, nurses, parents, and stakeholders. The MSDH SIDS program provided educational materials to childcare facilities, faith and community base organizations. Other activity during the year includes adding SIDS awareness information in the Childcare Licensure Newsletter and a news release on the MSDH's social media sites (i.e., Facebook, Twitter). The program mailed approximately 48,000 brochures to hospitals statewide entitled: What a Safe Sleep Environment Looks Like, Baby's Safe Sleep Crib Checklist, and Creating a Safe Sleep Environment for Baby.

By December 2014, efforts will be made to increase infant safe sleep practices by 5 percent. In order to accomplish this goal a partnership will be developed with the Mississippi State Fire Marshal's office to provide Direct On Site Education SIDS training for firefighters. Through this training, firefighters will gain knowledge about SIDS, be able to identify a safe sleep environment, and provide SIDS education to families whose homes they visit with a child less than one year of age. Initiatives will also be implemented to incorporate standard SIDS education into the PRHM Partner's for Healthy Babies Curriculum. MSDH partnered with the MS SIDS Alliance and the Cribs for Kids Program during 2013 to distribute 46 cribs to families identified with an infant less than one year of age with an unsafe sleep environment. The SIDS Program collaborated with the Newborn Screening Program to conduct a survey that incorporated the four PRAMS questions related to safe sleep. The results of the survey are being analyzed.

The SIDS Program will continue to identify best practices from other states to help reduce SIDS deaths and infant mortality. In collaboration with the Child Death Review Panel, the SIDS Program will continue to promote safety among children.

With funding from the Ronald McDonald Foundation, PRHM/ISS is working with two delta hospitals to provide newborn nursery professionals education about safe sleep using the NICDH nursing curriculum and provides literature about "room sharing versus bed sharing", onesies with the message about the "ABC's of safe sleep", and safe swaddle sacks for the hospitals to give out to new mothers. Approximately 45 hospital staff were trained. A third hospital received PowerPoint training and created a mandatory on-line training for staff.

**Health Status Indicators 08B:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*



HSI #08B - Demographics (Total deaths)

<b>CATEGORY</b> Total deaths	<b>Total NOT Hispanic or Latino</b>	<b>Total Hispanic or Latino</b>	<b>Ethnicity Not Reported</b>
Infants 0 to 1	331	6	5
Children 1 through 4	69	3	0
Children 5 through 9	36	1	0
Children 10 through 14	49	0	0
Children 15 through 19	120	3	0
Children 20 through 24	237	8	0
Children 0 through 24	842	21	5

**Notes - 2015**

**Narrative:**

In 2014 through an Office of Minority Health Grant, The Office of Health Disparity Elimination entered into a contract with the National Center for Cultural Competence to provide a series of webinars among MSDH staff and federally qualified community health centers staff that focus on three areas: Cultural Competence, Linguistic Competence and the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). These trainings will facilitate an improved cross-cultural communication between Low English Proficiency (LEP) patients and the MSDH staff by providing interpretation and translation assistance to the MSDH districts, field, departments and programs. It will also encompass outreach work in the community, assist district and county level staff to understand and respond effectively to the cultural and linguistic needs of the agency patients, assist with interpretation services at the District level, provide assistance to the different MSDH departments and programs in the translation of agency materials from English to Spanish, the revision of previously translated forms, the training of interpreters, and serve outreach workers within the various communities. The MSDH Office of Health Disparity Elimination also employs Outreach Coordinators to provide guidance on multicultural perspectives including those of the Middle Eastern and Hispanic communities and to assist with the certification of MSDH translators.

**Health Status Indicators 09A:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

<b>CATEGORY</b> Misc Data BY RACE	<b>Total All Races</b>	<b>White</b>	<b>Black or African American</b>	<b>American Indian or Native Alaskan</b>	<b>Asian</b>	<b>Native Hawaiian or Other Pacific Islander</b>	<b>More than one race reported</b>	<b>Other and Unknown</b>	<b>Specific Reporting Year</b>
All children 0 through 19	832997	434950	366164	6080	7412	495	17896	0	2012
Percent in household headed by single parent	49.0	14.5	83.6	0.1	0.1	0.0	0.7	0.9	2010
Percent in TANF (Grant) families	44.0	14.6	82.8	0.2	0.1	0.0	2.2	0.0	2013
Number enrolled in	446403	148062	265974	2598	2562	218	0	26989	2013

Medicaid									
Number enrolled in SCHIP	97720	43416	50065	628	993	65	0	2553	2013
Number living in foster home care	5583	2668	2651	11	24	6	121	102	2013
Number enrolled in food stamp program	300841	94879	197017	1563	734	85	6528	35	2013
Number enrolled in WIC	78319	18692	50414	181	1565	209	2720	4538	2013
Rate (per 100,000) of juvenile crime arrests	1346.0	790.8	2058.3	213.8	364.3	0.0	0.0	0.0	2013
Percentage of high school drop-outs (grade 9 through 12)	16.0	13.8	18.2	29.5	8.5	0.0	0.0	0.0	2012

#### Notes - 2015

Data provided by MS Department of Human Services

For Other and Unknown race, the number of juvenile crime arrests is 202. Mississippi Vital Records does not generate statistics for the Other/Unknown race. Since the total population data for Other/Unknown race is not available, rate of juvenile crime arrests has not been calculated.

#### Narrative:

In 2014 through an Office of Minority Health Grant, The Office of Health Disparity Elimination entered into a contract with the National Center for Cultural Competence to provide a series of webinars among MSDH staff and federally qualified community health centers staff that focus on three areas: Cultural Competence, Linguistic Competence and the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). These trainings will facilitate an improved cross-cultural communication between Low English Proficiency (LEP) patients and the MSDH staff by providing interpretation and translation assistance to the MSDH districts, field, departments and programs. It will also encompass outreach work in the community, assist district and county level staff to understand and respond effectively to the cultural and linguistic needs of the agency patients, assist with interpretation services at the District level, provide assistance to the different MSDH departments and programs in the translation of agency materials from English to Spanish, the revision of previously translated forms, the training of interpreters, and serve outreach workers within the various communities. The MSDH Office of Health Disparity Elimination also employs Outreach Coordinators to provide guidance on multicultural perspectives including those of the Middle Eastern and Hispanic communities and to assist with the certification of MSDH translators.

**Health Status Indicators 09B:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.*  
(Demographics)

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY	Total NOT	Total	Ethnicity Not	Specific
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Miscellaneous Data BY HISPANIC ETHNICITY	Hispanic or Latino	Hispanic or Latino	Reported	Reporting Year
All children 0 through 19	802025	30972	0	2012
Percent in household headed by single parent	98.8	1.2	0.0	2010
Percent in TANF (Grant) families	98.0	2.0	0.0	2013
Number enrolled in Medicaid	419414	16490	10499	2013
Number enrolled in SCHIP	95167	2552	1	2013
Number living in foster home care	4490	178	15	2013
Number enrolled in food stamp program	295455	5386	0	2013
Number enrolled in WIC	70204	3633	4482	2013
Rate (per 100,000) of juvenile crime arrests	1382.0	413.3	0.0	2013
Percentage of high school drop-outs (grade 9 through 12)	80.8	19.2	0.0	2012

## Notes - 2015

### Narrative:

In 2014 through an Office of Minority Health Grant, The Office of Health Disparity Elimination entered into a contract with the National Center for Cultural Competence to provide a series of webinars among MSDH staff and federally qualified community health centers staff that focus on three areas: Cultural Competence, Linguistic Competence and the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). These trainings will facilitate an improved cross-cultural communication between Low English Proficiency (LEP) patients and the MSDH staff by providing interpretation and translation assistance to the MSDH districts, field, departments and programs. It will also encompass outreach work in the community, assist district and county level staff to understand and respond effectively to the cultural and linguistic needs of the agency patients, assist with interpretation services at the District level, provide assistance to the different MSDH departments and programs in the translation of agency materials from English to Spanish, the revision of previously translated forms, the training of interpreters, and serve outreach workers within the various communities. The MSDH Office of Health Disparity Elimination also employs Outreach Coordinators to provide guidance on multicultural perspectives including those of the Middle Eastern and Hispanic communities and to assist with the certification of MSDH translators.

## F. Other Program Activities

### SIDS Program

*/2015/ The Program provides a statewide system for identification, counseling, and referral services as needed for families with sudden unexplained infant deaths. SIDS risk reduction is the primary focus of educational activities. The SIDS program has provided health education materials at SIDS trainings sponsored by the National Institute of Child Health and Human Development. The Program partners with the Perinatal High Risk Management Program (PHRM), MSDH Immunizations, MS SIDS Alliance, Cribs for Kids, MS Department of Human Services Children's Trust Fund, Lead Poisoning Prevention and Healthy Homes Program, and childcare facilities throughout the state to train childcare providers and staff on risk reduction. The program mails monthly What a Safe Sleep Environment Look Like, Baby's Safe Sleep Crib Checklist and Creating a Safe Sleep Environment for Baby brochures to hospitals statewide. The state is part of HRSA's Collaborative Improvement and Innovation Network (COIIN) Safe Sleep Team and focuses*

***on two of the three COIIN Strategies: Standardize Provisions of Safe Sleep Education and Training for Providers and Develop Strategic Alliances and Cooperative Partnerships to Endorse AAP Safe Sleep Recommendations and Promote Safe Sleep.***

***In May 2013, The Infant Sleep Positions in Birthing Hospitals Survey offered insight into the nurses' knowledge of current hospital policies related to infant safe sleep positions, adherence to AAP guidance, and parent safe sleep education. Approximately 53% of the respondents reported that they were aware of hospital's infant sleep positioning policies, 81% reported adhering to AAP guidance for infant safe sleep positioning in the hospital, and 79% reported providing parents with appropriate infant safe sleep positions education.***

***The number of SIDS deaths in the state declined by more than half from 2011 to 2012 (21 deaths in 2012 compared to 43 in 2011) according to a 10/11/13 Clarion-Ledger article citing MSDH statistics. //2015//***

#### Family Planning

/2014/ The Family Planning (FP) program has changed its name to "Comprehensive Reproductive Health" to better characterize the nature of the broad range of services and continuous outreach efforts to target populations while also reflecting the long-term strategic plan of the Agency. //2014//

CDC recommends that women take 400 micrograms of folic acid every day for at least one month before getting pregnant to help prevent birth defects. The Family Planning Program provides folic acid tablets to all family planning clients. Folic acid information is also provided to those who visit MSDH county clinics for a blood test for marriage.

/2012/ Dysplasia services are provided through coordinated care with initial and follow up visits and diagnostic procedures to include colposcopy, biopsy, cryosurgery, and loop electrosurgical excision procedures LEEPs). //2012//

#### Child Death Review (CDR) Panel

The CDR panel reviews data related to infant and child mortality. The primary purpose is to reduce infant and child mortality and morbidity in Mississippi, and to improve the health status of infants and children age 0 to 17 years of age. The CDR Panel is composed of fifteen voting members including the State Medical Examiner or his representative, a pathologist on staff at the University of Mississippi Medical Center, and an appointee of the Speaker of the House of representatives. The remaining representatives are appointed from a variety of state agencies and private advocacy organizations. The chairman of the review panel is elected annually by panel members while the MSDH houses the CDR Panel Coordinator.

In 2008, a law was passed mandating booster seats for children of a certain age and size and in 2009 a law was passed strengthening requirements for obtaining graduated driver's licenses.

/2013/ In 2010, a law was passed which prohibited the sale of novelty lighters. Bills passed in 2011 related to the well-being of children, such as the ATV/ORV helmet mandate for children under 16, with vehicle operator having either a driver's license or safety certificate. Also passed in 2011 was a law to study and make recommendations on reform of State Mental Health services for children, youth, and adults. In 2011, "Nathan's Law" was passed which increased fines for passing a stopped school bus.

In 2011, the CDR Panel began using the National Child Death review database and the Hinds County death review team was organized. This local team reviews deaths of Hinds County residents between the ages of birth and 17 years. The team meets every other month to review

cases and their findings and recommendations are reported to the state team for inclusion in the annual report. //2013//

## Nutrition Services

The Nutrition Services Program, as mentioned in the section above, serves in an advisory capacity to internal and external programs. The primary focus is to encourage a healthier lifestyle by means of improved nutrition and increased physical activity throughout the agency and state. The MSDH Nutrition Director is the national chair-elect for the Fruits and Veggies More Matters council.

Nutrition Services promotes changes in nutrition guidelines for child care centers throughout the state. The changes were implemented July 2009 and include stricter meal guidelines to incorporate more variety of fruits and vegetables, to change to more whole grains and to limit the use of fats, salt, and sugars in the meal and snack preparation. Centers are also encouraged to offer water with each meal and snack. Vending services are discouraged and must follow strict guidelines so presently no centers offer vending. In changing the guidelines and promoting a positive approach to fighting obesity, Nutrition Services, with the help of Childcare Licensure, offers "Menu Writing 101" to discuss the nutrition changes and how to implement healthier meals in child care centers. Classes are offered throughout the state.

/2012/ Nutrition Services Director evaluates over half the menus in the state for child care centers. Centers have noted that feeding the children healthier foods has not increased their food costs and children are eating better. //2012//

***/2015/ Nutrition guidelines were revised in May 2013 to encourage more fruits and vegetables and limit other foods. This is covered in earlier text. //2015//***

Since Mississippi is the most obese state, MSDH offers programs to fight obesity. Bodyworks, a program for 9-16 year old youth and caregivers, is being implemented throughout the state in many different arenas and focuses on parents as role models and provides them with hands-on tools to make small, specific behavior changes to prevent obesity and help maintain a healthy weight. MSDH offers a monthly "Train-the-Trainer" one day course to prepare health advocates throughout the state to implement this program in their communities through Women's Health.

***/2015/ Bodyworks training has been put on hold. Funding through the national Office of Women's Health has stopped for the toolkits. The organizations that were benefiting from this program lack funding to print materials. //2015//***

To address infant mortality through the PHRM program where nutritionists statewide work, a workshop was developed to address high risk pregnant women and their infants.

/2012/ Workshop was completed. Nutrition continues to work with the PHRM program and DIME and MIME clients. //2012//

***/2015/ PHRM has been revamped. Funding has been secured within the state to also implement "Healthy Families of America" to follow the high risk woman and infant for a longer time. We will start with a targeted area after training is completed. //2015//***

Nutrition Services works with the WIC program to address the educational needs of the staff and WIC clients. Breastfeeding rates have declined in Mississippi. With the assistance of the WIC Breastfeeding Coordinator, Nutrition Services promotes breastfeeding at many educational events, through the media, with childcare centers, and with the agency and all clients that we serve.

Education is a primary goal of Nutrition Services. Pamphlets, handouts, posters, cooking

demonstrations and food samplings are utilized to promote a healthier lifestyle. Community and professional education through media, lectures, "lunch-n-learn" series, workshops, and health fairs/screenings is encouraged throughout the agency and state.

***/2015/ The Nutrition Director serves a more active role with worksite, Farm to School, and wellness initiatives throughout the state. We have cooking demonstrations, grocery tours, and have placed over 125 healthy recipes on our website. Nutrition Services has a limited staff of one but continues to participate in over 5 regional/state events each month. //2015//***

#### MCH Toll-Free Hotline

The Mississippi MCH hotline is available on the MSDH website under the Information Desk link found on the home page. In CY 09, the hotline received 2,051 calls.

/2012/ During CY 2010, 1,667 calls were received on the toll free MCH hotline. This line provides assistance to clients seeking MCH services and/or information. Publicity for this service is provided through the MSDH website, brochures, pamphlets, and patient educational materials printed by MSDH. MSDH will continue to monitor the utilization of this line and seek strategies for improvement. //2012//

/2013/ During CY 2011, 1,541 calls were received on the toll free MCH hotline. //2013//

/2014/ There were 1,342 calls on the Take Care Line for CY 2012. //2014//

***/2015/ There were 1,355 calls on the MCH toll free hot line for FY 2013. //2015//***

## G. Technical Assistance

The MSDH is not requesting technical assistance in 2010. However, as part of an AMCHP collaborative effort among the HRSA Region IV states, there may be a pooled request for technical assistance during the upcoming grant period to convene and fund a meeting to discuss regional data and strategies to decrease teen birth rates across the southeast.

Teen birth and pregnancy rates serve as indicators for several poor outcomes including less stimulating home environments, worse behavioral and academic outcomes, and infant death. On a national level, according to the National Center for Health Statistics' 2009 State Profile for Mississippi, our state had the highest teen birth rate in the nation, 63 percent higher than the United States rate. Within the state, blacks had a 71 percent higher teen birth rate than whites according to the Guttmacher Institute. Related to this, teens make up almost 40 percent of those diagnosed with sexually transmitted diseases in Mississippi, and MSDH figures show that the number of HIV/AIDS cases among 15-to 24 year olds increased from 131 in 2007 to 160 in 2008.

/2012/ As part of a regional collaborative, Mississippi is submitting two requests for technical assistance on Form 15. The requests are listed below.

Request # 1 - Region IV Title V Directors continue to explore the possibility of a regional performance measure. State Health Officers in Regions IV and VI have come together and identified premature birth and infant mortality as a priority and are also discussing the potential of states in these two regions identifying common measures. Bringing the Title V Directors and key partners (e.g. Medicaid peers) from Region IV and VI together for technical assistance to develop common measures and explore evidence-based and promising practices to impact infant mortality. The technical assistance would need to include strategies that consider poverty, health equity, diversity/minority health, and social marketing.

Request # 2 - Mississippi (MS) has implemented a promising practices interconception program that addresses prevention of a repeat very low birthweight baby by providing case managed

preconception health, family planning, reproductive life planning, and access to healthcare and vocational assistance. Because this project has been translated in rural MS through health department clinics, complete fidelity to the original protocol has been a challenge. MS requests technical assistance to complete a process evaluation of this ongoing intervention. The technical assistance would need to include strategies that consider staff delivery of the intervention, documentation of implementation, and financial cost benefit analysis. //2012//

## V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>1. Federal Allocation</b> (Line1, Form 2)	9616373	8313482	9510148		9110217	
<b>2. Unobligated Balance</b> (Line2, Form 2)	0	0	0		0	
<b>3. State Funds</b> (Line3, Form 2)	7212280	10759376	7132611		6832663	
<b>4. Local MCH Funds</b> (Line4, Form 2)	0	0	0		0	
<b>5. Other Funds</b> (Line5, Form 2)	0	0	0		0	
<b>6. Program Income</b> (Line6, Form 2)	0	0	0		3699561	
<b>7. Subtotal</b>	16828653	19072858	16642759		19642441	
<b>8. Other Federal Funds</b> (Line10, Form 2)	81006367	79762582	93935997		79762582	
<b>9. Total</b> (Line11, Form 2)	97835020	98835440	110578756		99405023	

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Federal-State MCH Block Grant Partnership</b>						
<b>a. Pregnant Women</b>	5048596	6619786	4992828		5892733	
<b>b. Infants &lt; 1 year old</b>	0	0	0		0	
<b>c. Children 1 to 22 years old</b>	5048596	6045782	4992828		5892732	
<b>d. Children with</b>	5048596	5618358	4992828		5892732	



<b>Special Healthcare Needs</b>						
<b>e. Others</b>	0	0	0		0	
<b>f. Administration</b>	1682865	788932	1664275		1964244	
<b>g. SUBTOTAL</b>	16828653	19072858	16642759		19642441	
<b>II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).</b>						
<b>a. SPRANS</b>	0		0		0	
<b>b. SSDI</b>	65357		66392		91045	
<b>c. CISS</b>	0		0		0	
<b>d. Abstinence Education</b>	0		0		0	
<b>e. Healthy Start</b>	0		0		0	
<b>f. EMSC</b>	0		0		0	
<b>g. WIC</b>	71658021		84577473		71192906	
<b>h. AIDS</b>	0		0		0	
<b>i. CDC</b>	0		0		0	
<b>j. Education</b>	4372987		4409878		4032770	
<b>k. Home Visiting</b>	0		0		0	
<b>k. Other</b>						
<b>Title X</b>	4910002		4882254		4445861	

#### Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Direct Health Care Services</b>	9087473	5777600	5658538		5892733	
<b>II. Enabling Services</b>	841433	2535882	2496414		2553517	
<b>III. Population-Based Services</b>	1346292	2665011	1830704		2749942	
<b>IV. Infrastructure Building Services</b>	5553455	8094365	6657103		8446249	
<b>V. Federal-State Title V Block Grant Partnership Total</b>	16828653	19072858	16642759		19642441	

#### A. Expenditures

The MSDH will expend funds for the four tiers of services (infrastructure building, population-based, enabling, and direct health care). Services will target the three MCH population groups of pregnant women, mothers, and infants; children and adolescents; and children with special health care needs, with an emphasis on those in families living at or below 185 percent of the federal poverty level. This includes services to be provided or coordinated for individuals by category of individual served and source of payment or for budgeting/accounting/auditing for each capacity building activity described in the Annual Plan (e.g., public health leadership and education, assessment, policy development, planning, technical assistance, standard setting, quality assurance, and the like).

Personnel are employed to develop and implement standards of care as well as to directly provide services to clients. Classes of employees include physicians, social workers, nurses, nurse practitioners, nutritionists, health aides and clerical staff. Employees are required to meet

the standards for practice as specified by their professional organization.

Travel is reimbursed for official duty at the state authorized rate of \$0.51 per mile effective January 1, 2010. Government contract rates for lodging and per diem ceilings for subsistence are also utilized.

/2012/ There is no change in the mileage reimbursement rate for 2011. //2012//

/2013/ The mileage reimbursement rate increased to \$0.555 per mile effective April 17, 2012. //2013//

/2014/ The mileage reimbursement rate increased to \$0.565 per mile effective January 1, 2013. //2014//

**/2015/ The mileage reimbursement rate decreased to \$0.56 per mile effective December 23, 2013. //2015//**

Minor medical and office equipment, not major medical equipment, may be purchased in order to administer the program. The equipment items are small parts of the budget. State regulations governing purchase of equipment are strictly followed.

Supplies include the necessary clinical and office materials to operate the programs and to deliver patient care. Supplies are purchased centrally and according to purchasing policy of state government.

Contractual reflects funds budgeted to purchase services from outside providers. Examples would be for high risk medical care for women and CSHCN.

Construction: none

Other includes telephone, copying and postage used on behalf of the Title V block grant program.

## **B. Budget**

The budget for Mississippi's Title V MCH Block Grant application was developed by MSDH Health Services in cooperation with the Office of Health Administration, Finance and Accounts. The total program for FY 2010 is \$18,486,681 of which \$10,537,408 (57 percent) is Title V and \$7,949,273 (43 percent) is match provided in-kind by the applicant. Sources of match funds are state funds, Medicaid earnings (as allowed by the MCH Bureau), and other Third Party earnings. Other federal funds available to support the MCH objectives are listed on Form 4.

/2012/ The total program for FY 2011 is \$18,486,681 of which \$10,537,408 (57 percent) is Title V and \$7,949,273 (43 percent) is match provided in-kind by the applicant. //2012//

/2013/ The total program for FY 2013 is \$16,828,653 of which \$9,616,373 (57 percent) is Title V and \$7,212,280 (43 percent) is match provided in-kind by the applicant. //2013//

/2014/ Budget figures for FY 2014 do not substantially differ from previous years. Any federal budget and/or state match cuts to the Title V program will be reflected in budget forms 2-5. See forms 2-5 for budget details. Changes in program activities resulting from any budget cuts will be described in the state narrative section of the grant. //2014//

**/2015/ Budget figures for FY 2015 do not substantially differ from previous years with the exception of the inclusion of Program Income on Form 2, which consequently affects budget figures on Forms 3-5. See forms 2-5 for budget details. Modifications in program activities resulting from these budget changes will be described in the state narrative**

**section of the grant.**

***The Mississippi Division of Medicaid's managed care program, Mississippi Coordinated Access Network (MississippiCAN), had as its initial target population pregnant women and children up to age one; however, during the 2014 Mississippi Legislative session MississippiCAN was enlarged to now include all children. MississippiCAN was launched in 2011, and there are now about 140,000 Mississippians enrolled with the program's two coordinated care providers, United HealthCare and Magnolia Health Plan. As a result of this move to managed care, MSDH programs stand to suffer devastating impacts to their budgets including, for example, the Children's Medical Program (CMP), which is the MSDH program for children and youth with special health care needs. Medicaid reimbursements for CMP encounters alone will be reduced by 62%. Budget cuts akin to this are an important reminder of the tremendous importance of stable and adequate Title V funding going forward. //2015//***

#### Pregnant Women and Infants

Services for pregnant women and infants are budgeted as follows for FY 2010: \$3,161,223 for federal funds (30 percent of the total federal award), \$2,702,753 for non-federal funds (34 percent of total non-federal funds).

/2012/ Services for pregnant women, mothers, and infants are budgeted as follows for FY 2011: \$3,161,224 for federal funds (30 percent of the total federal award) and \$2,702,753 for nonfederal funds (34 percent of total non-federal funds). //2012//

/2013/ Services for pregnant women, mothers, and infants are budgeted as follows for FY 2013: \$2,884,912 for federal funds (30 percent of the total federal award) and \$2,163,684 for non-federal funds (30 percent of total non-federal funds). //2013//

/2014/ Budget figures for FY 2014 do not substantially differ from previous years. Any federal budget and/or state match cuts to the Title V program will be reflected in budget forms 2-5. See forms 2-5 for budget details. Changes in program activities resulting from any budget cuts will be described in the state narrative section of the grant. //2014//

***/2015/ Budget figures for FY 2015 do not substantially differ from previous years with the exception of the inclusion of Program Income on Form 2, which consequently affects budget figures on Forms 3-5. See forms 2-5 for budget details. Modifications in program activities resulting from these budget changes will be described in the state narrative section of the grant.***

***The Mississippi Division of Medicaid's managed care program, Mississippi Coordinated Access Network (MississippiCAN), had as its initial target population pregnant women and children up to age one; however, during the 2014 Mississippi Legislative session MississippiCAN was enlarged to now include all children. MississippiCAN was launched in 2011, and there are now about 140,000 Mississippians enrolled with the program's two coordinated care providers, United HealthCare and Magnolia Health Plan. As a result of this move to managed care, MSDH programs stand to suffer devastating impacts to their budgets including, for example, the Children's Medical Program (CMP), which is the MSDH program for children and youth with special health care needs. Medicaid reimbursements for CMP encounters alone will be reduced by 62%. Budget cuts akin to this are an important reminder of the tremendous importance of stable and adequate Title V funding going forward. //2015//***

#### Child and Adolescent Health

Services for the Child and Adolescent Health program are budgeted as follows for FY 2010:

\$3,161,223 for federal funds (30 percent of the total federal award), \$2,623,260 for non-federal funds (33 percent of total non-federal funds).

/2012/ Services for preventive and primary care for children are budgeted as follows for FY 2011: \$3,161,222 for federal funds (30 percent of the total federal award), \$2,623,260 for non-federal funds (33 percent of total non-federal funds). //2012//

/2013/ Services for preventive and primary care for children are budgeted as follows for FY 2013: \$2,884,912 for federal funds (30 percent of the total federal award) and \$2,163,684 for nonfederal funds (30 percent of total non-federal funds). //2013//

/2014/ Budget figures for FY 2014 do not substantially differ from previous years. Any federal budget and/or state match cuts to the Title V program will be reflected in budget forms 2-5. See forms 2-5 for budget details. Changes in program activities resulting from any budget cuts will be described in the state narrative section of the grant. //2014//

***/2015/ Budget figures for FY 2015 do not substantially differ from previous years with the exception of the inclusion of Program Income on Form 2, which consequently affects budget figures on Forms 3-5. See forms 2-5 for budget details. Modifications in program activities resulting from these budget changes will be described in the state narrative section of the grant.***

***The Mississippi Division of Medicaid's managed care program, Mississippi Coordinated Access Network (MississippiCAN), had as its initial target population pregnant women and children up to age one; however, during the 2014 Mississippi Legislative session MississippiCAN was enlarged to now include all children. MississippiCAN was launched in 2011, and there are now about 140,000 Mississippians enrolled with the program's two coordinated care providers, United HealthCare and Magnolia Health Plan. As a result of this move to managed care, MSDH programs stand to suffer devastating impacts to their budgets including, for example, the Children's Medical Program (CMP), which is the MSDH program for children and youth with special health care needs. Medicaid reimbursements for CMP encounters alone will be reduced by 62%. Budget cuts akin to this are an important reminder of the tremendous importance of stable and adequate Title V funding going forward. //2015//***

#### Children With Special Health Care Needs

Services for children with special health care needs are budgeted as follows for FY 2010: \$3,161,223 for federal funds (30 percent of the total federal award), \$2,623,260 for total nonfederal funds (33 percent of total non-federal funds).

/2012/ Services for children with special health care needs are budgeted as follows for FY 2011: \$3,161,222 for federal funds (30 percent of the total federal award), \$2,623,260 for total nonfederal funds (33 percent of total non-federal funds). //2012//

/2013/ Services for children with special health care needs are budgeted through the state's Children's Medical Program as follows for FY 2013: \$2,884,912 for federal funds (30 percent of the total federal award) and \$2,163,684 for total nonfederal funds (30 percent of total nonfederal funds). //2013//

/2014/ Budget figures for FY 2014 do not substantially differ from previous years. Any federal budget and/or state match cuts to the Title V program will be reflected in budget forms 2-5. See forms 2-5 for budget details. Changes in program activities resulting from any budget cuts will be described in the state narrative section of the grant. //2014//

***/2015/ Budget figures for FY 2015 do not substantially differ from previous years with the***

**exception of the inclusion of Program Income on Form 2, which consequently affects budget figures on Forms 3-5. See forms 2-5 for budget details. Modifications in program activities resulting from these budget changes will be described in the state narrative section of the grant.**

**The Mississippi Division of Medicaid's managed care program, Mississippi Coordinated Access Network (MississippiCAN), had as its initial target population pregnant women and children up to age one; however, during the 2014 Mississippi Legislative session MississippiCAN was enlarged to now include all children. MississippiCAN was launched in 2011, and there are now about 140,000 Mississippians enrolled with the program's two coordinated care providers, United HealthCare and Magnolia Health Plan. As a result of this move to managed care, MSDH programs stand to suffer devastating impacts to their budgets including, for example, the Children's Medical Program (CMP), which is the MSDH program for children and youth with special health care needs. Medicaid reimbursements for CMP encounters alone will be reduced by 62%. Budget cuts akin to this are an important reminder of the tremendous importance of stable and adequate Title V funding going forward. //2015//**

#### Administrative Costs

Administrative costs are budgeted at \$1,053,740 which is 10 percent of the total federal grant award. This amount does not exceed the allowable 10 percent of the total Title V MCH Block Grant as mandated in OBRA 1989.

/2013/ Administrative costs are budgeted as follows: \$961,637 which is 10 percent of the total federal grant award and \$721,228 which is 10 percent of the non-federal state match. These amounts do not exceed the allowable 10 percent of the total Title V MCH Block Grant as mandated in OBRA 1989. //2013//

/2014/ Budget figures for FY 2014 do not substantially differ from previous years. Any federal budget and/or state match cuts to the Title V program will be reflected in budget forms 2-5. See forms 2-5 for budget details. Changes in program activities resulting from any budget cuts will be described in the state narrative section of the grant. //2014//

**//2015/ Budget figures for FY 2015 do not substantially differ from previous years. Any federal budget and/or state match changes to the Title V program will be reflected in budget forms 2-5. See forms 2-5 for budget details. Modifications in program activities resulting from these budget changes will be described in the state narrative section of the grant. //2015//**

#### Maintenance of Effort

Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2010 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989.

/2012/ Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2011 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989. //2012//

/2013/ Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2013 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989. //2013//

/2014/ Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2014 is greater than the State's "maintenance of effort" level, i.e., the

total amount of State funds expended for maternal and child health program in FY 1989. //2014//

***/2015/ Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2015 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989. //2015//***

Matching funds for the Title V MCH Block Grant are identified by listing all direct program costs which have been paid from non-federal sources. These expenses include travel, medicine, medical services, clinical, and lab supplies. Funds used to match Medicaid or other grants are deducted.

All salary and non-salary charges for the Children with Special Health Care Needs program are identified by budget. The agency time study provides a report of the value of staff time paid from state or county funds. Time coded to Family Health, Family Planning, Maternity, Perinatal High Risk Management and other Maternal and Child Health efforts is used to match the pregnant women, mothers, and infants group. Time coded to Child Health, Oral Health, and School Nurse is used to match the children and adolescent group.

/2014/ The Mississippi State Department of Health is working to develop a system that will accurately differentiate the amount of program funds that are collected/earned by the MCH programs from insurance payments, Medicaid, HMOs, etc., for the reporting year. The system currently in place cannot adequately differentiate funds specifically designated for the MCH programs. Therefore, "0" will be entered into the "Program Income" line until MSDH is able to implement a new system.

***/2015/ A more accurate representation of "Program Income" was entered for the 2015 application. //2015//***

#### Funding From Private Sources

In an era of dwindling federal budgets and scarce state resources, our private partners can make the difference in whether existing programs can continue to meet goals and objectives or new programs can be initiated. Following are two examples where private funders are stepping up to assure sufficient financial resources are available to promote and protect the health of all Mississippians.

#### The Bower Foundation

Title V MCH Block Grant support helps the State Oral Health Program (SOHP) leverage additional resources, including funding from the Preventive Health & Health Services Block Grant and the Bower Foundation, a private philanthropic organization. The Bower Foundation is currently providing over \$1 million over a three year period which is used to match funding from the Preventive Health & Health Services Block Grant (40% Bower/60% PHHSBG) to design and install new community water fluoridation systems. The Mississippi Public Water Fluoridation Program is celebrating ten years this year that The Bower Foundation has provided funding to assure the oral health of Mississippi children and adults.

#### The Kellogg Foundation

The goal of the Pregnancy Risk Assessment Monitoring System (PRAMS) is to improve the health outcomes of mothers and infants by collecting information on a select number of women who have given birth in the state of Mississippi. Using confidential surveys of women who have had a recent live birth, PRAMS identifies and monitors selected maternal experiences and behaviors that occur before, during, and shortly after pregnancy that may have affected the health of their baby. With this information, the program seeks to eliminate adverse birth outcomes such

as low birth weight, infant morbidity and mortality, and maternal morbidity.

MS PRAMS receives \$100,000 in annual Kellogg grant funding through a partnership with the CDC Foundation and the W.K. Kellogg Foundation. The funding is for MS PRAMS to enhance data collection and outreach among high risk minority populations while Kellogg evaluates its maternal and child health work in these areas. The selected counties include Coahoma, Harrison, Hinds, and Sunflower counties. With Kellogg support, MS PRAMS now oversamples non-white, minority women in these counties, collaborates with community partners for outreach activities, and is exploring alternative data collection methodology. The goal is to increase MS PRAMS response rates in oversampled areas and collect quality, county level data. MCH partners can then utilize PRAMS data to design programming, increase awareness, change policies, and improve the health of high risk MCH populations in the state. //2014//

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.